THE RIGHT TO DIE: A REVIEW OF THE CURRENT STATUS OF NEW YORK LAW; THE DERIVATION OF THE PRINCIPLES AND THE ETHICAL CONSIDERATIONS; CURRENT REVIEW OF THE LAWS THROUGHOUT THE UNITED STATES

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I. INTRODUCTION

Whose life is it anyway? Is it God's life? Is it my family's life? Is it society's life? Is it my doctor's life? Is it my life? Who am I? Am I a minor? Am I an incompetent person? Am I a woman with child? Am I a comatose patient? Am I a terminally ill patient?

I am a young woman afflicted with cerebral palsy and degenerative arthritis, almost completely paralyzed, suffering continued pain and needing constant nursing care with no chance of recovery, but my doctors expect me to live and continually degenerate for the next 15 to 20 years. Do I have the right to starve myself to death? Do I have the right to a death with dignity?

Why does society call this suicide? Why can't I commit suicide? Why can't someone help me to have a death with dignity? Why is euthanasia wrong? Whose life is it anyway?

Can my physician withhold or withdraw treatment that seems only to prolong the process of my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery? Can my physician withhold or withdraw treatment that seems only to prolong the process of my dying, if I should be in an incurable terminal condition? Can my physician withhold or withdraw treatment

that seems to prolong the process of my dying if I am conscious but have irreversible brain damage and will never again regain the ability to make decisions and express my wishes? If I am conscious do I have the right to tell my physician that I do not want cardiac resuscitation, mechanical respiration, tube feeding and/or antibiotics?

It has been said:

> We are not a humane society. Our old people are discards and yet we're not allowed to make our own decisions. We are captives of our own people. A concentration camp in war could not be any more cruel or less caring for the dignity of the individual than our physicians and lawmakers.[1]

> Dying is not what it used to be. Today nearly ninety percent of all Americans succumb to chronic degenerative conditions rather than to sudden death.[2] Death usually occurs in hospitals and nursing homes where life-supporting technology offers the ability to keep some terminally ill patients[3] alive almost indef-

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[1]Letter from Lois Martin to director of Hemlock, an American Right-to-Die Society (quoted in Fadiman, The Liberation of Lolly and Gronky, Life, Dec. 1986, at 71, 72).

[2]Report of the President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 16-18 (1983)

[3]For the purposes of this Comment, terminal illness means an incurable condition caused by injury, disease, or illness from which there is no reasonable chance of recovery or cure, and which will, within reasonable medical judgment, produce death in the foreseeable future, in the absence of life-sustaining treatment. See Cohen, Interdisciplinary Consultation on the Care of the Critically Ill and Dying: The Role of One Hospital Ethics Committee, 10 Critical Care Med. 776, 781 (1982).

This Comment includes among the terminally ill those persons in a persistent vegetative state. The term "persistent vegetative

initely.[4] Because of these developments, however, many people now fear dying more than death.[5]

We face a dilemma, since most members of our society are morally and ethically repulsed by suicide.

Suicide supporters who maintain that some suicides are ethical usually claim that death can be a benefit to the individual who commits suicide[6] and that suicide can sometimes benefit others by relieving them of the burden of supporting an individual who has lost the desire or ability to continue

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state" refers to a form of unconsciousness arising from severe disruption of the coordinated functions of the brain caused by a physical or chemically induced injury. Ingvar, Brun, Johansson & Samuelson, Survival after Severe Cerebral Anoxia with Destruction of the Cerebral Cortex: The Apallic Syndrome, 315 Annals N.Y. Acad. Sci. 184 (1978). Patients in a persistent vegetative state may appear wakeful and their brain stems maintain subsistence activities and reflexes, however, they suffer a complete loss of the higher functions of speech, voluntary muscular activity, directed emotions, and signs of memory. Id. at 202. Detectable electroencephalograph (EEG) activity may or may not occur. President's Comm'n, supra, at 175. If nutrition is supplied to persons in a persistent vegetative state, the vegetative functions of sleep/wake cycles, respiration, circulation, temperature control, and uncontrolled excretion and evacuation will continue. Id.

[4]Childress, Refusal of Lifesaving Treatment by Adults, 23 J. Fam. L. 191, 194 (1984-85). Probably 80% of the deaths in the United States now occur in hospitals and long term care facilities such as nursing homes. President's Comm'n, supra note 1, at 16-18.

[5]Cassel, Deciding to Forego Life-Sustaining Treatment: Implications for Policy in 1985, 6 Cardozo L. Rev. 287, 288 (1984) See also Cantor, Conroy, Best Interests, and the Handling of Dying Patients, 37 Rutgers L. Rev. 543, 556, 571, 574-75 (1985)

[6]See, e.g., D. Humphry, Jean's Way (1984); G. Williams, The Sanctity of Life and the Criminal Law 277 (1957); Barrington, Apologia for Suicide, in Suicide: The Philosophical Issues 90, 93 (1980).

living a full life.[7] Common to both aspects of the ethical argument is a vigorous assault on the assumption traditionally accepted by law and society,[8] that all human lives are essentially and equally valuable. Instead, the "quality of life," rather than the "sanctity of human life," is considered the focus of inquiry.[9] Under certain circumstances, such as age, pain, terminal illness, or inability to feel that the benefits in one's life outweigh its burdens, preserving life may be less humane and less rational than ending it.[10] Similarly, preservation of one life may impact adversely on the quality of other lives.

The purpose of this article is to attempt to define generally and specifically according to New York State law the terms death, terminal condition, life sustaining treatment, severely and irreversibly demented patients, elderly patients with permanent mild impairment of

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[7] See, e.g., G. Williams, supra, at 97-99. The view that death is ethically appropriate when one is a burden on others or on society as a whole can lead to the position that under at least some circumstances death is ethically mandatory, and that compulsion by the state or other individuals is justified to bring it about. See, e.g., J. Fletcher, Humanhood: Essays in Biomedical Ethics 155 (1979).

[8] For the longstanding acceptance of this assumption, see generally Sherlock, Liberalism, Public Policy and the Life Not Worth Living: Abraham Lincoln on Beneficent Euthanasia, 26 Am. J. Juris. 47, 51-55 (1981).

[9] See, e.g., J. Fletcher, Humanhood, supra note 7, at 174.

[10] See, e.g., D. Richards, Sex, Drugs, Death and the Law 221 (1982); Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide, 49 N.Y.U. L. Rev. 227, 232 (1974).

competence, infants and minors, and persons under a legal disability. In addition, this article will trace the historical attitudes toward suicide in general and in New York in particular; to define euthanasia both active and passive whether voluntary or involuntary; to trace the derivation of the right of every individual to control his body and the exceptions thereto; to report the current status of the law in New York; to give the current status of law throughout the United States on the subject of the right to die; and lastly to present the moral, ethical and philosophical dilemmas confronting society concerning these issues.

II. DEFINITIONS

A. Death

Article 43 of the Public Health Law of the State of New York[11] does not define "death" or "the time of death" and there presently exists a discrepancy between the common law criteria for determining death, which are the easily observable absence of heartbeat and respiration,[12] and the medically recognized concept of "brain death" [13]

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[11] N.Y. [Public Health] Law Sec. 4300 (McKinney 1985).

[12] Black's Law Dictionary, 4 Ed. Rev. 1968, p. 488.

[13] As defined by criteria formulated by the Harvard Medical School's Ad Hoc Committee to Examine the Definition of Brain Death (Report of the Ad Hoc Committee of the Harvard Medical School, JAMA 205:337-340, 1968;) see also, Refinements in Criteria for the Determination of Death: An Appraisal, JAMA 221:48-53, 1972).

In the case of New York City Health & Hosps. Corp. v. Sulsona,[14] the patient was admitted to the hospital in a comatose condition due to a gunshot wound to the head. He was totally unresponsive, did not breathe or move spontaneously, and was placed on "mechanical respiratory support systems." He was thereafter declared neurologically dead according to generally accepted medical standards.[15]

Medical technology today is capable of sustaining an individual in permanent and irreversible coma for an indefinite period of time. Problems such as those presented in the Sulsona case, spawned by such technological achievements, prompted the Ad Hoc Committee of the Harvard Medical School in 1968 to propose a re-examination of the very definition of death:

> From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes; so the obvious criterion of no heart beat as synonymous with death was sufficiently accurate. In those times the heart was considered to be the control organ of the body; it is not surprising that its failure marked the onset of death. This is no longer valid when modern resuscitative and supportive measures are used. These improved activities can now restore 'life' as judged by the ancient standards of persistent respiration and continuing heart beat. This can be the case even when there is not the remotest possibility of an individual recovering consciousness following massive brain

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[14] 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (1975).

[15] Id. at 1004, 367 N.Y.S.2d at 688-89.

damage.[16]

Increasingly, more individuals are drawn to the view that the "ultimate horror is not death but the possibility of being maintained in limbo, in a sterile room, by machines controlled by strangers."[17] Thus, while the law has traditionally regarded death as an event, i.e., the cessation of circulatory and respiratory functions, medical science has come to recognize death as a process.[18] Several

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[16]Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death, A Definition of Irreversible Coma, 205 J.A.M.A. 337, 339; see, also, Matter of Quinlan, 70 N.J. 10, 355 A.2d 647 at p. 656, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976), overruled in part, In Re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); Matter of Dinnerstein, 6 Mass. App. 464, 380 N.E.2d 134, 135-136, n.2.

[17]Steel, The Right to Die: New Options in California, 93 Christian Century [July-Dec. 1976]; Confronting Death With Dignity, 14 Wake For. L. Rev. 771; Raible, The Right to Refuse Treatment and Natural Death Legislation, Medicolegal News, vol. 5, no. 4, at p. 7.

[18] See, e.g., Smith v. Smith, 229 Ark. 579, 586, 317 S.W.2d 275, 279 (1958); Thomas v. Anderson, 96 Cal. App.2d 371, 376, 215 P.2d 478, 481-82 (1950).(In these cases the definition has been applied to resolve questions involving implications of death). The legal consequences resulting from confusion over the definition of death were illustrated in Douglas v. Southwestern Life Ins. Co., 374 S.W.2d 788, 794 (Tex. Civ. Ct. of Appeals, 1964)(beneficiary of a Texas decedent could not recover accidental death benefits under the decedent's insurance policy inasmuch as recovery depended on death ensuing within 90 days and the decedent was kept "alive" by sophisticated medical care for a period in excess of 90 days). Id. See also, Collester, Death, Dying and the Law: A Prosecutorial View of the Quinlan Case, 30 Rutgers L. Rev. 304,, 307 (1978)(a discussion of the confusion as to the proper definition of death); Note, The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State, 51 N.Y.U. L. Rev. 285, 285-288 (1976)(a discussion of various definitions of death); Comment, The Criteria for Determining Death in Vital Organ Transplants -- A Medico-Legal Dilemma, 38 Mo. L. Rev. 220, 221-223 (1973)(a discussion of present and future definitions of death); Wasmuth, The Concept of Death, 30 Ohio St. L. J. 33, 36-37 (1969)(a clinical definition of death);

pre-eminent medical panels -- including the Ad Hoc Committee of Harvard Medical School -- have attempted to resolve this dilemma by postulating new criteria for the determination of death, commonly referred to as "brain death."[19] This

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Annotation, Tests of Death for Organ Transplant Purposes, 76 A.L.R.3d 913 (1977).

[19] Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death, supra, note 16, at 338. The proposed criteria for brain death recognized by the Ad Hoc Committee of Harvard Medical School included (1) lack of receptivity and response to externally applied stimuli; (2) no movements or breath; (3) no reflexes; and (4) a flat EEG, indicating a total absence of brain activity. Id. See also, Hirsch & Donovan, The Right To Die: Medico-Legal Implications of In Re Quinlan, 30 Rutgers L. Rev. 267, 291-294 (1978); Hirsch, Brain Death: Medico-Legal Fact or Fiction? 3 N. Ky. St. L. F. 16, 17-19 (1975)(discussion on how some of these criteria have proved difficult to utilize in practice). The highest court of one State has essentially adopted a brain death standard by judicial fiat. Commonwealth v. Golston, 373 Mass. 249, 366 N.E.2d 744, 747-748, cert. den., 434 U.S. 1039 (1978). Moreover, in 1978, the National Conference of Commissioners on Uniform State Laws approved the "Uniform Brain Death Act" as follows: "For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards." Uniform Brain Death Act Sec. 1, 12 U.L.A. 16 (Pocket Part 1978). The Commissioners' comment that the word "functioning" in the section "expresses the idea of purposeful activity in all parts of the brain as distinguished from random activity," thus conceivably encompassing the terminally ill patient in irreversible coma. Id. The subject is of more than academic interest since it may well provide the Legislature with the most expeditious solution to this complex problem. See Generally, R. Veatch, Death, Dying and the Biological Revolution (1989); Capron & Kass, A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal, 121 U. Pa. L. Rev. 87 (1973).

Compare the Ad Hoc Committee of Harvard Medical School in the American Academy of Neurology's "Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient" adopted by its Executive Board on April 21, 1988:

> 1. The persistent vegetative state is a form of eyes-open permanent unconsciousness in which the patient has periods of

wakefulness and physiologic sleep/wake cycles, but at no time is the patient aware of himself or his environment. Neurologically, being awake, but unaware is the result of a functioning brain stem, and the total loss of cerebral cortical functioning.

A. No voluntary action or behavior of any kind is present. Primitive reflexes and vegetative functions which may be present are either controlled by the brain stem or are so elemental that they require no brain regulation at all.

Although the PVS patient generally is able to breathe spontaneously because of the intact brain stem, the capacity to chew and swallow in a normal manner is lost because these functions are voluntary, requiring intact cerebral hemispheres.

B. The primary basis for the diagnosis of PVS is the careful and extended clinical observation of the patient, supported by laboratory studies. PVS patients will show no behavioral response whatsoever over an extended period of time. The diagnosis of permanent unconsciousness can usually be made with a high degree of medical certainty in cases of hypoxic-ischemic encephalopathy after a period of one to three months.

C. Patients in a persistent vegetative state may continue to survive for a prolonged period of time ("prolonged survival"), as long as the artificial provision of nutrition and fluids is continued. These patients are not "terminally ill."

D. Persistent vegetative state patients do not have the capacity to experience pain or suffering. Pain and suffering are attributes of consciousness requiring cerebral cortical functioning, and patients who are permanently and completely unconscious cannot experience these symptoms.

There are several independent bases for the neurological conclusion that PVS patients do not experience pain or suffering.

First, direct clinical experience with these patients demonstrates that there is no behavioral indication of any awareness of pain or suffering.

Second, in all PVS patients studied to date, post-mortem examination reveals overwhelming bilateral damage to the

solution, however, has not as yet been accepted as legally conclusive of the issue in this State.

Let us examine the medical findings in the Matter of Storar (sometimes referred to herein as the "Brother Fox)[20] and the Quinlan[21] cases and compare them to the criteria for brain death as recognized by the Ad Hoc Committee of Harvard Medical School.

In Quinlan, Karen Quinlan was admitted to the hospital in a deep coma of unknown origin. Three days after admission, a specialist examined her and found "evidence of decortication" which is described as damage to the brain evidenced by "a physical posture in which the upper extremities are fixed and the lower extremities are extended." Additionally, she was on a respirator.[22] Karen

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cerebral hemispheres to a degree compatible with consciousness or the capacity to experience pain or suffering.

Third, recent data utilizing positron emission tomography (PET) indicates that he metabolic rate for glucose in the cerebral cortex is greatly reduced in PVS patients, to a degree incompatible with consciousness.

Position of the American Academy of Neurology on Certain Aspects of the Core and Management of the Persistent Vegetative State Patient, American Academy of Neurology, April 21, 1998 p. 1-2.

[20] 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981).

[21] Matter of Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom, Garger v. New Jersey, 429 U.S. 922 (1976), overruled in part, In Re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

[22] Id. at 654. Results of an electroencephalograph (EEG) were abnormal, but demonstrated activity "consistent with her clinical state." Id. Results of a brain scan, angiogram, and lumbar puncture were normal. Id. Dr. Morse, Karen's treating physician,

was further characterized as being in a "chronic persistent vegetative state,"[23] defined as someone "who remains with the capacity to maintain the vegetative parts of neurological function but who no longer has any cognitive function."[24]

It was the belief of experts who testified that Karen was not "brain dead" as defined by the Ad Hoc Committee of Harvard Medical School,[25] finding that she met none of the Committee's criteria for brain death.[26].

Dr. Plum testified that the brain works in essentially two ways:

> We have an internal vegetative regulation which controls body temperature which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart rate, which controls chewing, swallowing and which controls sleeping and waking. We have a more highly developed brain which is uniquely human which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think. Brain death necessarily must mean the death of both of these functions of the

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testified that there were two basic types of coma: "sleep-like unresponsiveness and awake unresponsiveness." Id. While initially in the sleep-like unresponsive state, Karen followed a normal medical progression to "sleep-awake" cycles, during which she could blink, cry out, etc., while still totally "unaware of anyone or anything around her." Id.

[23] Id.

[24] Id.

[25] Id.

[26] Id.

> brain, vegetative and the sapient. Therefore, the presence of any function which is regulated or governed or controlled by the deeper parts of the brain which in laymen's terms might be considered purely vegetative would mean that the brain is not biologically dead.[27]

The experts believed that Karen could not survive without the assistance of the respirator. Further, they testified that it was unknown exactly how long she would live without the assistance of a respirator and it was likely death would follow soon after its removal.[28] The medical experts also agreed that Karen was in a "persistent vegetative state,"[29] from which she would never recover.[30]

Let us now look at the Eichner[31] case. While undergoing surgery, Brother Fox suffered a cardiac arrest leading to brain damage.[32] He was thereafter placed on a respirator,[33] which his attending physician described as an "extraordinary method of life support" used only in the most

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[27] Id at p. 654.

[28] Id. at 655.

[29] Id. For definition of "persistent vegetative state," see supra, note 3.

[30] Id.

[31] In re Storar, 52 N.Y. 2d 363, 420 N.E. 2d 64, 438 N.Y.S. 2d 266, cert. denied, 454 U.S. 858 (1981).

[32] Id. at 269.

[33] Id. at 269.

critical of cases,[34] and lapsed into a coma.[35]

In a hearing to determine whether the extraordinary life support could be terminated, the medical testimony was consistent in that Brother Fox was not brain dead, since his EEG demonstrated "minimal activity,"[36] but was in a persistent vegetative state, although the doctors were not certain whether his condition had stabilized. Medical testimony also was consistent in concluding that Brother Fox would never recover the "sapient powers of the brain"[37] and that death was inevitable either with or without the respirator.

The Court of Appeals concluded that the physical condition of Brother Fox was identical to Karen's condition in the Quinlan case and that there was clear and convincing evidence that he did not wish to be maintained in a persistent vegetative state by use of a regulator.[38] The Court therefore permitted the respirator to be removed.[39]

B. Terminal Condition

"Terminal condition means an incurable and irreversible condition that without the administration of life-sustaining treatment, will, in the opinion of the

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[34] Id. at 270.

[35] Id. at 270.

[36] Id. at 270.

[37] Id. at 273.

[38] 52 N.Y. 2d 363, 380.

[39] Id. at 383.

attending physician, result in death within a relatively short time."[40]

C. Life Sustaining Treatment

Life Sustaining Treatment means any medical procedure or intervention that when administered to a qualified patient, will only serve to prolong the process of dying.[41] Life prolonging medical procedures and intervention also includes medication and artificially or technologically supplied respiration, nutrition or hydration.[42] In Delio v. Westchester County Medical Center,[43] Judge Thompson stated: "In our review of the decision in other jurisdictions we failed to uncover a single case in which a court confronted with an application to discontinue feeding by artificial means has evaluated medical procedures to provide nutrition and hydration differently from other types

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[40] Unif. Rights of the Terminally Ill Act, Sec, 1(9) 9B U.L.A. 609 (1985) (amended 1987, 1989). Cf. N.Y. Public Health Law Sec. 2961(19) (McKinney 1985 & Supp. 1989)(amended 1987)(this source puts forth an untested definition of "terminal condition." It is defined as an ". . . illness or injury from which there is no recovery, and which reasonably can be expected to cause death within one year.")

[41] Section 1(4), Uniform Rights of the Terminally Ill Act which was approved by the National Conference of Commissions on Uniform State Laws in 1985 as amended in 1987 and 1989. Note, sections 1(4) and (9) are interdependent and must be read together.

[42] See generally, Buchanan, The Limits of Proxy Decisionmaking for Incompetents, 29 U.C.L.A. L. Rev. 386 (1981) and Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L. Rev. 1 (1975-1976).

[43] 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987).

of life-sustaining procedures[.][44]

It should also be noted that the definition of life-sustaining treatment ignores the distinction between ordinary and extraordinary means of medical treatment -- administration that is considered crucial in some medical decision-making -- because it is not relevant in refusal of treatment cases.[45] There are four common modes of administering artificial nutrition and hydration.[46]

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[44] The Court went on to list a number of cases it had reviewed: Bouvia v. Superior Court of Los Angeles County, 179 Cal. App.3d 1127, 225 Cal. Rptr. 297; Barber v. Superior Court for Los Angeles County, 147 Cal. App.3d 1006, 195 Cal. Rptr. 484; Corbett v. D'Alessandro, 487 So.2d 368 [Fla.]; Matter of Hier, 18 Mass. App. 200, 464 N.E.2d 959, review denied, 392 Mass. 1101, 465 N.E.2d 261); see also, Siegal, In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment, 6 Pace L. Rev. 219, 260-261 [1968] [approving the Conroy court's refusal to distinguish between artificial feeding and other medical treatment]; Merritt, Equality for the Elderly Incompetent: A Proposal for a Dignified Death, 39 Stan. L. Rev. 689, 716 n.180 [1987] quoting from President's Commn. for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment, 190; cf., Harber, Withholding Food and Water from a Patient -- Should It Be Condoned in California?, 16 Pac. L. J. 877 [1985]). Id.

[45] Barber v. Superior Court for Los Angeles County, 147 Cal. App.3d 1006, 195 Cal. Rptr. 484 (1983); Siegal, In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment, 6 Pace L. Rev. 219, 260-261 (1986).

[46] 1) Nasogastric tube: A tube is inserted into the nose, down the back of the mouth, down the length of the esophagus, into the stomach.

2) Gastrostomy tube: Under anesthesia, a surgical procedure is performed, creating a passage through the abdominal wall into the stomach. Liquid food is passed directly through the "stoma," or hole, via a tube.

3) Intravenous tube: A needle is inserted into a vein in one of the patient's extremities, and a tube is connected to

D. Severely and Irreversibly Demented Patients[47]

"Patients in this category, usually the elderly, are at one end of the spectrum of decreasing mental capacity. They do not initiate purposeful activity but passively accept nourishment and bodily care."[48]

E. Elderly Patients With Permanent Mild Impairment of Competence[49]

"Many elderly patients are described as pleasantly

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the needle through which fluids are delivered into the body. Usually the vein is too small to carry long-term adequate nutrition.

4) Hyperalimentation: Under anesthesia, a large needle is inserted into the subclavian vein (large vein behind the collar bone) through which chemically prepared nutrients enter the body. Like intravenous feeding, this too bypasses the gastrointestinal tract. See also, Barber v. Superior Court, 147 Cal. App.3d 1006, 195 Cal. Rptr. 484 (Ct. App. 1983); Bouvia v. Superior Court (Glenchur), 179 Cal. App.3d 1127, 225 Cal. Rptr. 297 (Ct. App. 1986), review denied, (Cal. June 5, 1986); Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); Corbett v. D'Alessandro, 487 So.2d 368 (Fla. Dist. Ct. App.), review denied, 492 So.2d 1331 (Fla. 1986); Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), cert. granted, 109 S. Ct. 3240 (1989); Conservatorship of Drabick, 200 Cal. App.3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988), rev. denied (Cal. July 28, 1988), cert. denied, 109 S. Ct. 399 (1988); Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (App. Div. 2d Dep't 1987); In re Gardner, 534 A.2d 947 (Me. 1987); In re Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987), modified, 757 P.2d 534 (1988); Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987); McConnell v. Beverly Enterprises, 209 Conn. 692, 553 A.2d 596 (1989);In re Peter, 108 N.J. 365, 529 A.2d 419 (1987); Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987).

[47] Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussin & Van Eys, The Physician's Responsibility toward Hopelessly Ill Patients, 310 New Eng. J. Med. 955, 958 (1984) [hereinafter Wanser].

[48] Id.

[49] Id. at 959.

senile." Although somewhat limited in their ability to initiate activities and communicate, they often appear to be enjoying their moderately restricted lives."[50]

F. Infant or Minor

The terms infant and minor are generally used interchangeably. An infant is a person under the age of 18 years.[51]

An infant is considered to be a person for many purposes of the law even before birth. The general rule is that a child en ventre sa mere is, from the time of conception, provided he is born alive, considered alive for all purposes for his benefit.[52]

G. Persons Under a Legal Disability

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[50] Id. at 959.

[51] Dom. Re. Law Sec. 2a (McKinney 1988); See also CPLR Sec. 125(;) (McKinney 1990); Gen. Obl. Law Sec. 1-202 (McKinney 1989).

[52] In re Meyer's Estate, 119 N.Y.S.2d 737, 752 (1953) quoting Matter of Holthausen's Estate, 175 Misc. 1022, 26 N.Y.S.2d 140, 143.

The existence of the child as a real person before birth is a fiction of law for the purpose of providing for and protecting the child, in the hope and expectation that he will be born alive and be capable of enjoying those rights which are thus preserved for him in anticipation. Drobner v. Peters, 232 N.Y. 222, 133 N.E. 567, 20 A.L.R. 1503 (ovrld on other grounds Woods v. Lancet, 303 N.Y. 349, 102 N.E.2d 691, 20 A.L.R.2d 1503 (1921). See also Woods v. Lancet, 303 N.Y. 349, 127 N.E. 2d 691, 27 A.L.R. 2d 1250, (the court overruled the earlier annotation as supporting the view denying such a child's right of recovery. The court, however, limited its holding to injuries to viable children). Annotations: Fetus as person on whose behalf action may be brought under 42 USCS § 1983. 64 A.L.R. Fed. 886. As to whether a child or its personal representative may maintain an action in damages for prenatal injury, see N.Y. Jur.2d, Torts.

The Mental Hygiene Law defines various terms used throughout this law.[53] Among these terms are "mentally disabled" and "mental disability," which are defined in the Mental Hygiene Law as legal terms used to refer generally to the separately defined conditions of "mental illness,"[54] "mental retardation,"[55] "developmental disability,"[56] "alcoholism,"[57] and "substance dependence."[58]

An "alcoholic" is defined as "any person who is

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[53] Men. Hyg. Law § 1.03.

[54] Id. at 1.03(20). "'Mental illness' means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment, and rehabilitation." Id.

[55] Id. at 1.03(21). "'Mental retardation' means subaverage intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." Id.

[56] Id. at Sec. 1.03(22)(a-d). "'Developmental disability' means a disability of a person which is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, autism; [and] . . . any other condition of a person found to be closely related to mental retardation, or to dyslexia caused by any of these other conditions, which disability originates before the person attains age 18, has continued or can be expected to continue indefinitely, and constitutes a substantial handicap to such person's ability to function normally in society." Id.

[57] Id. at Sec. 1.03(13). "'Alcoholism'" means a chronic illness in which the ingestion of alcohol usually results in the further compulsive ingestion of alcohol beyond the control of the sick person to a degree which impairs normal functioning. "Alcohol abuse" is defined in Men. Hyg. Law at Sec. 1.03(16) as any use of alcohol which interferes with the healthy, social or economic functioning of the individual or of society. Id.

[58] Id. at § 1.03(3), which provides, however, that for the purpose of Title 11 of Article 5 of the Soc. Serv. Law, the terms "mental disability" and "mentally disabled" do not include substance dependence.

afflicted with the illness of alcoholism."[59]

It is also provided by statute[60] that "the terms lunatic, mentally ill person, lunacy and mental illness include every kind of unsoundness of mind except idiocy or mental retardation."[61] A distinction has been recognized between lunatics and idiots. The former have lucid intervals while the latter have no power of mind whatsoever.[62]

It has been held that the term "imbecile" connotes mental deficiency yet the person is capable of some education, though not beyond the Binet ages of 3 to 7 years.[63] This differs from psychotic and insane in the sense that these labels "deal with a disorder of the mind often capable of correction under expert guidance and treatment with the use of modern techniques."[64] "Insane" is generally considered to be a much broader term, implying "every degree

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[59] Men. Hyg. Law Sec. 1.03(14). "Recovered alcoholic" is defined in Men. Hyg. Law Sec. 1.23(15) as a person with a history of alcoholism whose course of conduct over a sufficient period of time reasonably justifies a determination that the person's capacity to function normally within a social and economic environment is not, and not likely to be, destroyed or impaired by alcohol.

[60] N.Y. Gen. Constr. Law. Sec. 28 (McKinney Supp. 1990).

[61] Id.

[62] De Nardo v. De Nardo, 293 N.Y. 550, 552, 59 N.E.2d 241 (1944); Weinberg v. Weinberg, 255 A.D. 366, 368, 8 N.Y.S.2d 341, 344-45 (App. Div. 1938).

[63] People ex rel. Stavies v. Loughlin, 195 N.Y.S.2d 364, 369 (Sup. Ct. 1959), modified on other grounds, 11 A.D.2d 646, 201 N.Y.S.2d 150 (App. Div. 1960).

[64] Id.

of unsoundness of mind, including illnesses in which there may be remissions or mitigations."[65]

III. DERIVATION OF THE RIGHT OF EVERY INDIVIDUAL TO THE POSSESSION AND CONTROL OF HIS PERSON

A. Historical Attitudes Toward Suicide

It is extremely difficult, if not impossible, to find a specific reference to suicide in writings dating back to antiquity. In fact, it is equally as difficult to determine whether or not there was ever a term in Aramaic, Hebrew or Greek, equivalent to "suicide." Consequently, the issue of the morality of suicide was never directly addressed.[66]

However, throughout the Hebrew Bible there are several instances in which a person has committed suicide. More specifically, Abimelech committed suicide to escape the disgrace of being slain by a woman;[67] Samson destroyed the Philistines and himself by pulling down a Philistine temple;[68] Saul, when all hope of victory was lost, died by falling on

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[65] Weiss v. Weiss, 31 Misc. 2d 256, 258, 221 N.Y.S.2d 296, 300 (Sup. Ct. 1961)(Citation omitted).

[66] Daube, The Linguistics of Suicide, 1 Phil. & Pub. Aff. 387-437 (1972). Even in English, the term, derived from Latin suicidium, "to kill oneself," was not used until 1651.

[67] Judges 9:54.

[68] Judges 16:30.

his sword;[69] Ahithophel "hanged" himself when his counsel was refused;[70] Zimri burned himself in the royal citadel, apparently as a self-imposed judgment for his sins;[71] Ptolemy, a Syrian official who lost respect because of his leniency toward the Jews, poisoned himself;[72] Razis chose to commit suicide rather than fall prey to his enemies.[73]

The New Testament is also very ambiguous with respect to passing judgment on the morality of suicide. The one act of suicide contained within the New Testament is that of Judas Iscariot. Judas' case, however, is rather unique. Judas, after betraying Christ, shamefully hanged himself.[74] The Church strongly denounced Judas' act, viewing it as nothing more than dishonorable and disgraceful.[75]

For a long time there existed a great deal of confusion as to the discerning characteristics of suicide as opposed to martyrdom which stemmed from the copious examples of Christians who took their lives so as not to sacrifice their Christian beliefs. The issue was finally directly addressed by St. Augustine during the late Fourth Century.

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[69] 1 Samuel 31:4.

[70] 2 Samuel 17:23.

[71] 1 Kings 16:18.

[72] 2 Maccabees 10:113.

[73] Id. at 14:41.

[74] Matthew 27:5.

[75] 13 New Catholic Encyclopedia 782 (1967).

In light of several "heretical sects" which strongly encouraged suicide when faced with appropriate circumstances, and the Stoics who vilified Christian women for "not killing themselves when violated at the hands of Barbarians," Augustine felt obliged to make known his vehement opposition to any form of suicide, regardless of the circumstances under which it is done.[76]

Suicide is also a gray area in English Common Law. Glanvill, published around 1187, was the first significant English law treatise. Suicide is never mentioned in Glanvill. Relatively, soon thereafter, Bracton, in a formal written account of suicide advocated the ancient Roman law on suicide as presented in the Digest of the Emperor Justinian.[77] It is unclear, however, specifically what the law condemns:

> [W]here persons who have not yet been accused of crime, lay violent hands on themselves, their property shall not be confiscated by the Treasury; for it is not the wickedness of the deed that renders it punishable, but it is held that the consciousness of guilt entertained by the defendant is considered to take the place of a

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[76] P & L Landsberg, The Experience of Death and the Moral Problem of Suicide 45 (1953) at 77.

[77] For a detailed history concerning historical attitudes toward suicide from ancient to modern times, see Article, Suicide: A Constitutional Right?, 24 Duq. L. Rev. 1; The Treatise on the Laws and Customs of the Realm of England Commonly Called Glanvill (G. Hall ed. 1983); J. Baker, An Introduction to English Legal History 4-5, 412 (3d ed. 1990).

confession.[78]

However, if one is charged with a crime but not convicted of a felony and kills himself, his inheritance will then be the escheat of his lords.[79]

Bracton's own account is considerably less vague as to its direct addressing of suicide in particular, and his subsequent condemnation thereof: "[I]f a man slays himself in weariness of life or because he is unwilling to endure further bodily pain . . . he may have a successor, but his movable goods are confiscated. He does not lose his inheritance, only his movable goods."[80] In essence, the law maintained that suicide, on the part of any sane individual, was a felony, punishable by the confiscation of all personal property. As for the insane, Bracton wrote, "madman bereft of reason[,] . . . the deranged, the delirious and the mentally retarded . . . or . . . one laboring under a high fever" do not commit felony de se "nor do such persons

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[78]9 The Civil Law 129 (S. Scott trans. 1932) (Digest, bk. 48, tit. 21, para. 3 [1]. The general rule was that if an accused person died before judgment, then "his heirs can take possession of his estate." Id. at para 3).

[79]2 Bracton on the Laws and Customs of England 366 (fol. 130) & 423-24 (fol. 150) (G. Woodbine ed. S. Thorne trans. 1968). Bracton did not use the term "suicide" but referred to "felonia . . . de se ipso" (felony to [or upon] oneself). Id. at 366 and 423 (fol. 150).

[80]Id. at 423-24 (fol. 150). The Latin is almost identical (Bracton's divergences are in brackets): "non enim facti sceleritatem esse obnoxiam, sed conscientiae metum [metus] in reo velut [veluti pro] confesso teneri placuit [habetur] (in place of 'teneri placuit')." Id. at 424 & nn. 7-8 (fol. 150) and at 424 (fol. 150).

forfeit their inheritance or their chattels . . . .[81] Clearly, the law was monumental, as it officially introduced the subject of suicide into the English common law.

The law attracted little, if any attention, much less criticism, until 1716 when William Hawkins published the first edition of A Treatise of the Pleas of the Crown.[82] It was a scathing commentary criticizing the deplorable state of English common law. With respect to the law on suicide, he wrote, "Our laws have always had such an abhorrence of this crime. . . ."[83] However, he went on to explain that most coroner's juries during the Eighteenth Century believed that "every one who kills himself must be non compos of course; for it is said to be impossible that a man in his senses should do a thing so contrary to nature and all sense and reason."[84] Thus, Hawkins' criticism lies in the fact that, using the above reasoning, the laws would never apply to the insane, who were immune from any prosecution.[85] Clearly though, irrespective of his criticism of the futility of the laws regarding suicide, Hawkins strongly contributed to the ongoing contempt for suicide long held by the English

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[81] Id.

[82] W. Hawkins, A Treatise of the Please of the Crown (London 1716).

[83] W. Hawkins, A Treatise of the Pleas of the Crown 77 (J. Curwood ed. 8th ed. 1824).

[84] Id.

[85] Id.

people.[86]

In 1736, Sir Matthew Hale strengthened this contempt for suicide adding that:

> No man hath the absolute interest of himself, but 1. God almighty hath an interest and propriety in him, and therefore self-murder is a sin against God. 2. The King hath an interest in him, and therefore the inquisition in case of self-murder is felonice and voluntarie seipsum interfecit and merderarit contra pacem domini regis [feloniously and voluntarily killed and murdered himself against the peace of the lord king].[87]

He expressed his views through his extraordinarily influential work The History of the Pleas of the Crown.[88]

The law on suicide drew further attention in 1769, when Sir William Blackstone wrote Commentaries on the Laws of England.[89] Blackstone referred to suicide as "self-murder" condemning "the pretended heroism, but real cowardice of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure . . . ."[90] Blackstone was quite explicit in his condemnation of suicide and his philosophy has had a tremendous impact on

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[86] Id.

[87] M. Hale, Historia Placitorum Coronae, The History of the Please of the Crown *411-12. Hale took issue with Coke concerning whether a coroner's ruling of felo de se was conclusive or subject to challenge by executors and administrators. Id. at *414-17.

[88] Hale, supra.

[89] 4 W. Blackstone, Commentaries, 189-90.

[90] Id. at *189.

contemporary American Law. Furthermore, in his Commentaries, he gave a precise and comprehensive list of all his reasons why the act should be prohibited. In the Commentary, he explains:

> [T]he law of England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on oneself. . . .[91]

The early colonists of America would have been strong supporters of Blackstone. Suicide was a serious crime in the early settlements for until the late Eighteenth Century. In 1776, New Jersey and Maryland became the first states to establish statutory or constitutional provisions abolishing penalties for suicide. North Carolina, New Hampshire, Delaware, Rhode Island and Virginia soon followed.[92]

However, although suicide was no longer treated as a crime in virtually every legal arena, one must not

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[91] Id. at *189.

[92] Del. Const. of 1792, art. 1 § 15. Md. Const. of 1776, decl. of rts. § 24. N.H. Const. pt. 2, art. 89 (adopted 1783). N.J. Const. of 1776, art. 17. N.C. Const. of 1778. R.I. Pub. Laws § 53, at 604 (1798). Act of 1847, ch. 11, §§ 23, 25, 1847-48 Va. Laws 121, 124.

interpret that as an approval of the act. In reality, suicide was still strongly frowned upon. It was no longer punishable as a crime, however, because it was believed that the punishment served only to punish the suicide's innocent family and an unfeeling corpse. This idea was also extended to encompass punishments for attempted suicide as well. The public often felt sorry for potential suicides rather than contempt towards them as criminals. Clearly, it was believed, anyone who would attempt to take his or her own life could not be of sound mind, and thus should be treated with sympathy and helped rather than punished. This, however, did not infer that suicide was a condonable act, for they still believed that the act, in and of itself, was immoral and heretical. These views were summed up in a 1902 case in Pennsylvania, in which the judge declared:

> Calling suicide self-murder is a curt way of justifying an indictment and trial of an unfortunate person who has not the fortitude to bear any more of the ills of this life. His act may be a sin, but it is not a crime; it is the result of disease. He should be taken to a hospital and not sent to a prison. . . .[93]

B. Historical Attitudes Toward Suicide in New York State

In 1828, New York State acknowledged the assisting of a suicide as a crime. "At the common law, if one persuaded another to kill himself, the advisor was guilty of murder, and if the party took poison himself by the

[93] Commonwealth v. Wright, 11 Pa. D. 144, 146 (1902).

persuasion of another in the absence of the persuaded, yet it was a killing by the persuader."[94] The statute, however, reduced the grade of the offense from murder to manslaughter in the first degree.[95] With respect to suicide, New York State set the precedent for readopting the attitudes shared by the early colonists.

In an 1843 insurance case, the New York Supreme Court (a trial court) referred to sane suicide as "an act of criminal self-destruction."[96] The Court of Appeals, New York's highest court, remarked in 1871 in another insurance case, "[Suicide] is contrary to the general conduct of mankind; it shows gross moral turpitude in a sane person."[97]

In 1881, a new penal code was instituted. It incorporated several of the same ideas as the 1828 legislation. It extended, however, to include the justification of using force "in preventing an idiot, lunatic, insane person, or the person of unsound mind,

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[94] 1 J. Colby, Practical Treatise Upon the Criminal Law and Practice of the State of New York 612 (Albany 1868).

[95] Act of Dec. 10, 1828, ch. 209, § 4, 1828 N.Y. Laws 19, 19 (codified at 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, at 661 (1829); 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7 at 550 (1836); 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, at 750 (1846); 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, at 847 (1852); 3 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, at 940 (1858); 3 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, at 680-81 (1867); 3 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7, at 932 (1875)).

[96] Breasted v. Farmers' Loan and Trust Co., 4 Hill 73, 75 (1843), aff'd, 8 N.Y. 299 (1853).

[97] Mallory v. Travelers Ins. Co., 47 N.Y. 52, 54-55 (1871).

including persons temporarily or partially deprived of reason, from committing an act dangerous to himself . . . during such period only as shall be necessary to obtain legal authority for the restraint or custody of his person."[98]

In 1889, in Darrow v. Family Fund Society,[99] the New York Court of Appeals applied the rule that in "upholding the

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[98]Act of July 26, 1881, ch. 676, § 223 (6), 1881 N.Y. Laws (vol. 3 Penal Code) 1, 54 (codified at 4 N.Y. Laws Penal Law § 246(6), at 2555 (1909)).

The 1881 penal code also contained these provisions:

§ 172 Suicide is the intentional taking of one's own life.

§ 173 Although suicide is deemed a grave public wrong, yet from the impossibility of reaching the successful perpetrator, no forfeiture is imposed.

§ 174 A person who, with intent to take his own life, commits upon himself any act dangerous to human life, or which, if committee upon or towards another person and followed by death as a consequence, would render the perpetrator chargeable with homicide, is guilty of attempting suicide.

§ 175 A person who willfully, in any manner, advises, encourages, abets, or assists another person in taking the latter's life, is guilty of manslaughter in the first degree.

§ 176 A person who willfully, in any manner, encourages, advises, assists or abets another person in attempting to take the latter's life, is guilty of a felony.

§ 177 It is not a defense to a prosecution under either of the last two sections, that the person who took, or attempted to take, his own life, was not a person deemed capable of committing crime.

§ 178 Every person guilty of attempting suicide is guilty of felony, punishable by imprisonment in a state prison not exceeding two years, or by a fine not exceeding one thousand dollars, or both.

Act of July 26, 1881, Ch. 676, §223 (6), 1881 N.Y. Laws (Vol. 3 Penal Code) 1, 54 (Codified at 4 N.Y. Laws Penal Law §246 (6), at 2555 (1909) and at §§ 172-78, 1881 N.Y. Laws (vol. 3 Penal Code) at 42-43 (codified at 4 N.Y. Con. Laws, Penal Law §§ 2300 to 2306, at 2809-10 (1909)).

[99]116 N.Y. 537, 22 N.E. 1093 (1889).

contract of insurance, its provisions will be strictly construed as against the insurer,"[100] and ruled that death benefits for a suicide could be recovered despite language in the contract barring their recovery when the death was "in violation of or attempt to violate any criminal law . . . ."[101]

> At common law, suicide was a crime, and the consequence was the forfeiture of the chattels real and personal, of the felo de se. It is not a crime in this state. The attempt to commit suicide is made a crime . . . [A]n attempt to commit crime imports a purpose, not fully accomplished, to commit it . . . . It must, for the purpose of the question here, be assumed that Darrow had the purpose of taking his own life, and that he fully accomplished such purpose . . . By the act of taking his own life he violated no criminal law . . . .[102]

The strict penalties for suicide-related crimes continued. In 1903, Leland Kent was sentenced to 20 years in prison for "willfully aiding, encouraging, and assisting Ethel Blanche Dingle in committing suicide by cutting her throat[.]"[103] When an application for certificate was filed, the judge refused, stating: "[t]o allow a man convicted of such a crime to go at large when his guilt is so apparent, would tend to bring the administration of criminal justice

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[100] Id. at 544, 22 N.E. at 1095.

[101] Id. at 542, 22 N.E. at 1094.

[102] Id. at 542-43, 22 N.E. at 1094-95 (citations omitted).

[103] People v. Kent, 41 Misc. 191, 191, 83 N.Y.S. 948, 949 (Sup. Ct. 1903).

into disrepute."[104]

In 1903, the Court of Appeals overruled Darrow, holding in Shipmen v. Protected Home Circle[105] that a suicide committed while sane did not entitle the beneficiary to insurance benefits when the contract provided for no payments if the insured's death was caused by an illegal act of his own. As the Shipmen court stated:

> [I]n committing suicide the plaintiff's husband was guilty of a crime, and all crime is illegal. It is, to say the least, doubtful whether the rule of the common law, declaring suicide to be malum in se, has been abrogated by the provisions of our Penal Code; but whether we invoke the stern morality of the common law, or the more merciful decree of our own statute, which declares suicide to be a "grave public wrong," it may fairly be called an illegal act . . .
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> . . . No act so contrary to good morals and the usual course of human nature should be held to be within the contemplation of the parties to a contract for life insurance, unless it is clearly and unequivocally expressed.[106]

However, the tables again began to turn. Reiterating the charge of a 1902 jury in which the court explained that "suicide is too odious to be presumed; it must be proved"[107] a

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[104] Id. at 195, 83 N.Y.S. at 951.

[105] 174 N.Y. 398, 67 N.E. 83 (1903).

[106] Id. at 406, 67 N.E. at 85.

[107] Mitterwallner v. Supreme Lodge, Knights and Ladies of the Golden Star, 37 Misc. 860, 862-63, 76 N.Y.S. 1001, 1004 (City Ct. 1902).

1914 intermediate appellate court further tempered the strong anti-suicide attitudes prevailing in the courts.[108] In an insurance case, the court remarked, "[s]uicide, being unlawful and immoral, the presumption obtains in favor of mistake rather than suicide [in assessing a cause of death which could be either]."[109] This trend grew stronger until its abolishment in 1919 when the prohibitions and punishment for attempting suicide (set forth above as sections 174 and 178 of the 1881 Penal Code)[110] were repealed in 1919.[111]

This concept of presumptions in favor of mistake rather than suicide was further revised in 1944 by the New York Court of Appeals. It declared that not only should criminality not be assumed, but neither should moral turpitude, by holding: "[o]ne aspect of the broader rule that where evidence is susceptible of two constructions, the construction which does not imply criminality or moral turpitude is to be favored."[112]

In 1965, the Penal Law was completely revised. The section that had defined suicide and characterized it as a

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[108] Bernard v. Protected Home Circle, 161 A.D. 59, 146 N.Y.S. 232 (New York 1914).

[109] Id. at 62-63, 146 N.Y.S. at 235.

[110] Act of July 26, 1881, supra, note 98.

[111] Act of May 5, 1919, ch. 414 § 1, 1919 N.Y. Laws 1193.

[112] Wellisch v. John Hancock Mut. Life Ins. Co., 293 N.Y. 178, 184-5, 56 N.E.2d 540, 543 (1944).

"grave public wrong,"[113] and the section that prevented, as a defense to assisting suicide, the claim that the person assisted was incapable of committing a crime (set forth in sections 172, 173 and 177 of the 1881 Penal Code), were both omitted entirely.[114]

The punishments for aiding suicide, however, were made very stringent. Section 175 of the 1881 Penal Code was redrafted as follows: "A person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide."[115] Section 176 was revised to provide that "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide," which was considered a felony offense.[116] In addition, the legislature adopted a statute that in effect provided that one who, through "the use of duress or deception," caused or aided another to commit suicide, could be found guilty of murder.[117] Similarly, one

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[113] Act of July 26, 1881, supra, note 98.

[114] Penal Law, ch. 1030, § 500.05, 1965 N.Y. Laws 1704, 1717-47 (1965).

[115] Id. § 125.15(3) at 1584 (codified at N.Y. Penal Law Sec. 125.15(3)(McKinney 1975).

[116] Id. 120.30 at 1582 (codified at N.Y. Penal Law Sec. 120-30 (McKinney 1975).

[117] Penal Law, ch. 1030, § 125.25(1)(b), 1965 N.Y. Laws 2343, 2388 (codified at N.Y. Penal Law § 125.25(1)(b) (McKinney 1975)). See also Act of May 2, 1967, ch. 791, sec. 9, § 125.25(1)(b), 1967 N.Y. Laws 2131, 2137 (clarifying amendment); Penal Law, ch. 1030, § 120.35, 1965 N.Y. Laws 2343, 2385 (codified at N.Y. Penal Law § 120.35 (McKinney 1975)).

who "by the use of duress or deception," caused or aided another to attempt suicide could be convicted of attempted murder.[118]

In fact, the new found interest in focusing on those who aided a suicide continued to grow. Those who aided the suicide were the target of at least as much, if not more, contempt as the suicide himself. All laws relating to aiding a suicide were clarified and aiding a suicide officially and unequivocally became a serious offense; namely murder. Arnold Hechtman, in his "Practice Commentaries"[119] notes:

> This question is recognized and explicitly resolved in the Revised Penal Law. All cases of causing or aiding a suicide are prosecutable as second degree manslaughter . . . but those in which "duress or deception" is used by the defendant are also prosecutable as murder . . . . This rule is designed to restrict the more sympathetic cases to manslaughter and, at the same time, to permit the more heinous ones to be prosecuted as murder. Thus, a man who, upon the plea of his incurably ill wife, brings her a lethal drug in order to aid her in ending a tortured existence, is guilty at most of second degree manslaughter. On the other hand, a man who, in order to rid himself of an unwanted wife, deceitfully embarks upon an alleged suicide pact with her and then extricates himself according to plan, leaving her to die, is guilty of murder

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[118] Penal Law, ch. 1030, § 120.35, McKinney's 1965 Session Laws of New York 2343, 2385 (codified at N.Y. Penal Law § 120.35 (McKinney 1975))(current version at N.Y. Penal Law Sec. 125.25(1)(6)(McKinney 1987).

[119] N.Y. Penal Law § 125.15 practice commentaries (McKinney 1975)(current version at N.Y. Penal Law Sec. 125.15 practice commentaries (McKinney 1987)).

as well as of second degree manslaughter.[120]

Furthermore, in 1965, new legislation was passed declaring, that someone who reasonable believes "that another person is about to commit suicide or to inflict serious physical injury upon himself may use physical force upon such person to the extent that he reasonably believes it necessary to thwart such result."[121] These sentiments hold true through the present day. Under current law, a person who appears to be mentally ill and is conducting himself in a manner which poses substantial risk of physical harm to himself as manifested by threats or attempts at suicide, may be involuntarily detained.[122]

C. Euthanasia

Euthanasia, is "the act or practice of killing or permitting the death of hopelessly sick or impaired individuals . . . in a relatively painless way for reasons of mercy."[123] J. Fletcher, in Morals and Medicine, referred to it as a "merciful release from incurable suffering."[124] Although the legislatures in this country provide that no one may

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[120] Id.

[121] Penal Law, ch. 1030, § 35.10(4) & Table II, McKinney's 1965 Session Laws of New York 2343, 2355, 2495 (codified at N.Y. Penal Law § 35.10(4)(McKinney 1975))(current version at N.Y. Penal Law Sec. 35.10(4)(McKinney 1987)).

[122] N.Y. Mental Hyg. Law § 9.41 (McKinney 1988).

[123] Webster's Ninth New Collegiate Dictionary 429 (1983).

[124] J. Fletcher, Morals and Medicine 172 (1954).

actively aid and abet suicide, which, as previously noted, is a crime, they do not provide that a person may be prosecuted for remaining passive and not interfering. Passive euthanasia, however, is not subject to prosecution by the law.[125]

Euthanasia may be further classified as involuntary or voluntary. These classifications refer to the person who is dying. Involuntary euthanasia refers to the situation in which the person who ultimately dies was in a state of incompetence, unconsciousness or in any other state which disabled that person from giving his consent at the time the decision was made to allow, actively or passively, the person to die.[126] Conversely, active euthanasia occurs when the patient himself actively makes and/or consents to the decision to end his life.[127] Although passive euthanasia is legal both in the case of voluntary and involuntary, there is considerable confusion as to what constitutes passive euthanasia. Unplugging a respirator and switching off a dialysis machine are examples which lie in this gray area. Coincidently, both have generally been found to be passive euthanasia by the vast majority of courts in this country.[128]

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[125]W. Lave & A. Scott, Handbook on Criminal Law, § 74.

[126] See Fn 135

[127] See Fn 135

[128]See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical,

For the most part, however, these courts specify that this acknowledgement of a person's "right to die" is limited to a right to die naturally.[129]

Medical, and Legal Issues in Treatment Decisions 3 (1983) ("The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken . . . ."). [hereinafter cited as Report of President's Euthanasia Commission].

[129] Silving, supra, at 354. "[F]ailure [in the U.S.] to consider the ethical relevance of motive in criminal law results in circumvention of legal provisions, lack of uniformity of adjudication, and public dissatisfaction." Id. at 387. See, too, on this subject, O'Russell, Freedon to Die 53 (1975), Gillon, Suicide and Voluntary Euthanasia: Historical Perspective, in Euthanasia and the Right to Death 173-74 (A.B. Downing ed. 1969); cf. L. Dublin & B. Bunzel, To Be or Not To Be 183-84 (1933) (finding confusion in ancient Greek view of morality of suicide generally). W. Lave & A. Scott, Handbook on Criminal Law, § 74. The phrase "right to die," as used by most legislatures, courts, and commentators refers only to a right to die naturally. See, e.g., Natural Death Act, Ala. Code §§ 22-8A-1 to -10 (Cum. Supp. 1983) (permitting only "natural process of dying"); Death With Dignity, Ark. Stat. Ann. §§ 83-3801 to -3804 (Cum. Supp. 1983); Natural Death Act. Cal, Health & Safety Code §§ 7185-95 (West Cum. Supp. 1983) (permitting only "natural process of dying"); Natural Death Act, Wash. Rev. Code Ann. §§ 70.122.020-.122.905 (West Cum. Supp. 1983) (permitting only ("natural process of dying"); infra, notes 21-25 and accompanying text. See, generally, Freamon, Death with Dignity Laws: A Plea for Uniform Legislation, 5 Seton Hall Leg. J. 105, 119-21, 119-20 nn.78-79.

See J. Fletcher, supra, at 176. Involuntary euthanasia is the merciful killing of a person who does not request or consent to the act. The subject may or may not be capable of consent. See Gillon, supra, at 173. Some advocate involuntary euthanasia for seriously defective infants and patients suffering from senile dementia. See, e.g., G. Williams, The Sanctity of Life 347 (1957); Kamisar [hereinafter Kamisar], Euthanasia Legislation: Some Non-Religious Objections, in Euthanasia for the Right to Death, supra, at 112-13. The Nazis practiced involuntary euthanasia on many classes of persons not members of their "master race," including patients in mental institutions. See N. St. John-Stevas, supra, at 37-38; Kamisar, supra, at 115.

American courts have allowed involuntary euthanasia in certain cases. Although the opinion suggests otherwise, In re

There has long been much debate over voluntary active euthanasia and objections have been raised of both a religious and secular nature. Yale Kamisar offers an excellent presentation of the two main secular reasons for

Quinlan, 70 N.J. 10, 355, A.2d 647 (1976), is an example of involuntary euthanasia as defined in this Note. See Assisted Suicide: The Compassionate Crime 31 (D. Humphry ed. 1982) [hereinafter cited as Compassionate Crime]; see, also, In re Eichner, 73 A.D.2d 431, 467, 426 N.Y.S.2d 517, 544 (App. Div. 1980) (concluding that absent any countervailing compelling state interest, terminally ill patient in comatose and vegetable state has right to have life-prolonging medical treatment discontinued). In reaching its decision, the Quinlan court relied on the fiction that the decision by Karen's guardian to remove the respirator was actually Karen's own decision. Quinlan, 70 N.J. at 41, 355 A.2d at 664. Such legal fictions inhibit clear analysis of the interests involved and invite the type of abuse that concerns euthanasia critics. Karen, comatose throughout the proceedings, was incapable of making a choice concerning euthanasia. The court in effect sanctioned involuntary euthanasia.

Voluntary euthanasia occurs when the suffering incurable makes the decision to die. See J. Fletcher, supra, at 176. Fletcher states:

> Those who condemn euthanasia of both kinds would call the involuntary form murder and the voluntary form a compounded crime of murder and suicide if administered by the physician, and suicide alone if administered by the patient himself. As far as voluntary euthanasia goes, it is impossible to separate it from suicide as a moral category; it is, indeed, a form of suicide.

Id. Voluntary euthanasia may involve participation of second parties. See Silving, Euthanasia: A Study in Comparative Criminal Law, 103 U. Pa. L. Rev. 350, 359 (1954) ("Only where administered upon request, or at least with the consent of the deceased, can euthanasia be deemed comparable to assistance in suicide."). "[T]he time-honored rule that what one may lawfully do another may help him to do" underlies the right of a terminal patient to request assistance in the act of voluntary euthanasia. J. Fletcher, supra, at 176. See, generally, J. Roman, Exit House (1980).

See Sherlock, For Everything There is a Season: The Right to Die in the United States, 1982 B.Y.U. L. Rev. 545, 548.

opposing voluntary active euthanasia.[130] The arguments, in large part, are based on the concept that there are two primary risks which result from the act which, in light of their gravity and scale, make the benefits of the act almost insignificant and thus, the act inadvisable.[131]

The first risk is known as the "wedge principle."[132] This theory refers to a natural continuance in which the first step, namely the legalization of voluntary euthanasia, will inevitably lead to a predictable second step, the legalization of involuntary euthanasia. Thus, the fear is that, essentially once society accepts that life can be terminated because of diminished quality, there is no rational way to limit euthanasia and prevent its abuse.[133] Under this theory, it will be impossible to determine whether the act is committed as a result of an inner belief that the patient is a burden to himself or if the reason is of a more selfish or ignorant nature on the part of society in which they seek to kill because the patient is a burden to others. In essence, the morality of the first step "rests in part on what the second step is likely to be."[134]

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[130] See Kamisar, supra note 129.

[131] Id. at 36.

[132] Id. at 114.

[133] Id. at 115.

[134] Id. at 115. Kamisar notes that many public advocates of legalized voluntary euthanasia privately advocate legalized involuntary euthanasia as well. Id. at 106-110. He quotes Lord

The second concern pertains directly to the possible immediate ramifications of the first step itself; that is the legalization of voluntary active euthanasia. Kamisar opines that there would exist a great deal of room for both abuses and mistakes within the law.[135]

The fear of abuse stems from the possibility that self-interested doctors, nurses or family members, deprived of any altruistic concerns, may try and persuade a feeble patient into making an insincere decision which would serve only to achieve the selfish persons' ends. Thus, the vagueness of the term "voluntary" would cause many complications in establishing whether or not a decision is of such a nature. On a more innocent, less selfish note, there also exists the possibility that, due to the strains of the entire situation, a family member might unwittingly lose sight of the patient's true best interests and make a relatively irrational decision. Clearly, a great deal of difficulty exists in trying to establish a patient's true desire.

The "mistake" aspect of the problem is equally as

Chorley upon the Lord's introduction of the 1950 Voluntary Euthanasia Bill in the House of Lords:

> Another objection is that the bill does not go far enough, because it applies only to adults and does not apply to children who have come into the world deaf, dumb and crippled, and who have a much better cause than those for whom the Bill provides. That may be so, but we must go step by step. Id. at 107 (footnotes omitted).

[135] See id. at 96-106.

troubling. Misdiagnosis is the most obvious example of mistake; there also exists a possibility of a miraculous medical breakthrough. Clearly, these possibilities are relevant and must be considered when evaluating any sort of a decision about euthanasia.[136]

D. Schloendorff v. Society of New York Hospital[137]

In 1908, Mary Schloendorff was admitted to Society of New York Hospital with a stomach disorder. Her testimony was that, in order to render a diagnosis, the physicians had to perform an "ether examination."[138] She further testified that she consented to the "ether examination", but notified her physician that she did not want to undergo an operation.[139] During the course of the examination, a tumor was removed. This was done, according to plaintiff's testimony "without her consent or knowledge."[140] Subsequently, she developed gangrene of the arm, as a result of which some of her fingers were amputated. She then sued the hospital.[141]

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[136] Id. Kamisar argues that very few patients actually need euthanasia and those who claim to need it because of extreme pain can rely instead on pain relieving drugs. Id. at 104-05.

[137] 211 N.Y. 125, 105 N.E. 92 (1914), (overruled by Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957)(abandoning prior rule that accorded hospital immunity from negligence of employees)).

[138] Id. 127-28, 105 N.E. at 93.

[139] Id. at 128, 105 N.E. at 93.

[140] Id.

[141] Id. at 128, 105 N.E. at 93.

Judge Cordoza's opinion stated that

> . . . [T]he wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what should be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.(citations omitted).[142]

The right of a person to control his own body is a basic societal concept being long in common law:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.[143]

In the Matter of Storar and Eichner,[144] Judge Wachtler clearly restated the rule in New York as to a competent patient as follows:

> In this State, however, there is no statute which prohibits a patient from declining necessary medical treatment or a doctor from honoring the patient's decision. To the extent that existing statutory and decisional law manifests the State's interest on this subject, they consistently support the right of the competent adult to make his own

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[142] Id. at 130, 105 N.E. at 93.

[143] Union Pacific Railway Co. v. Botsford, 141 U.S. 250, 251, (1891).

[144] 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64 (1981).

> decision by imposing civil liability on those who perform medical treatment without consent, although the treatment may be beneficial or even necessary to preserve the patient's life.[145]

It was a firmly established principle of the common law of New York that every competent adult had a "right to determine what [should] be done with his own body,"[146] and to control the course of his medical treatment.[147] This tenet has been faithfully adhered to by our courts,[148] and recognized by our Legislature.[149]

In Storar,[150] it was recognized that a patient's right to determine the course of his medical treatment was paramount to what might otherwise be the doctor's obligation to provide medical care, and that the right of a competent

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[145] Id. at 377, 438 N.Y.S.2d at 273, 420 N.E.2d at 71 (emphasis added).

[146] Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914)(Cardozo, J.)

[147] See, Matter of Storar, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64; Schoendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, supra.

[148] See, Matter of Storar, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, supra; Matter of Harry M., 96 A.D.2d 201, 107, 468 N.Y.S.2d 359; see generally, People v. Eulo, 63 N.Y.2d 341, 357, 482 N.Y.S.2d 436, 472 N.E.2d 286; Hanes v. Ambrose, 80 A.D.2d 963, 437 N.Y.S.2d 784; Matter of Saunders v. State of New York, 129 Misc. 2d 45, 50, 492 N.Y.S.2d 510; Matter of Winthrop Univ. Hosp. v. Hess, 128 Misc. 2d 804, 490 N.Y.S.2d 996; Matter of Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Meyer, J.)

[149] Public Health Law §§ 2504, 2805-d; CPLR 4401-a; 10 NYCRR 405.25[a]]7].

[150] 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64.

adult to refuse medical treatment must be honored, even though the recommended treatment "may be beneficial or even necessary to preserve the patient's life."[151] In our system of a free government, where notions of individual autonomy and free choice are cherished, it should be the individual has the final say with respect to decisions regarding his medical treatment so that the greatest possible protection will be accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.[152] This right extends equally to mentally ill persons who should not be treated as persons of lesser status or dignity because of their illness.[153] As held by the Supreme Court of Oklahoma, "[i]f the law recognizes the right of an individual to make decisions about . . . life out of respect for the dignity and autonomy of the individual, that interest is no less significant when the individual is mentally or physically ill".[154]

It is well accepted that mental illness often

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[151] Id. at 377, 438 N.Y.S.2d at 266, 420 N.E.2d at 64.

[152] See, Matter of Erickson v. Dilgard, 44 Misc. 2d 27, 28, 252 N.Y.S.2d 705, supra; see generally, Olmstead v. United States, 277 U.S. 438, 478, 48 S. Ct. 564, 572, 72 L. Ed. 944 [Brandeis, J., dissenting]; Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251, 11 S. Ct. 1000, 1001, 35 L. Ed. 734; Davis v. Hubard, 506 F. Supp. 915, 930-933; Pratt v. Davis, 118 Ill. App. 161, 166, aff'd, 224 Ill. 300, 79 N.E. 562.

[153] Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417.

[154] In re K.K.B., 609 P.2d 747, 752 (Okla. 1980).

strikes only limited areas of functioning, leaving other areas unimpaired, and consequently, that many mentally ill persons retain the capacity to function in a competent manner.[155] Despite mental illness, an individual is not required to forfeit his civil rights[156] which includes the fundamental right to make decisions concerning one's own body.[157]

E. Is There a Constitutional Right to Suicide?

The claim that suicide is a right protected by the United States Constitution is based on the broad autonomy

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[155] See, Brooks, Constitutional Right to Refuse Antipsychotic Medications, 8 Bull. of Am. Academy of Psychiatry & L. 179, 191 [hereafter Constitutional Right]; Rogers v. Okin, 478 F. Supp. 1342, 1361) (D.Mass. 1979).

[156] See, Mental Hygiene Law § 33.01 (McKinney 1977).

[157] See, DuBose, Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia; Do the Benefits to the Patient Justify Involuntary Treatment, 60 Minn. L. Rev. 1149, 1160).See Rennie v. Klein, 653 F.2d 836, 846 [3rd Cir.], vacated and remanded, 458 U.S. 1199, 102 S. Ct. 3506, 73 L. Ed.2d 1381, on remand, 720 F.2d 266 [3rd Cir.]; Rogers v. Okin, 634 F.2d 650, 658-659 [1st Cir.]; Scott v. Plante, 532 F.2d 939 [3rd Cir.]; Winters v. Miller, 446 F.2d 65 [2nd Cir.]; Davis v. Hubbard, 506 F. Supp. 915, 935 [Ohio]; Matter of Anderson v. State of Arizona, 135 Ariz. 578, 663 P.2d 570; In re Boyd, 403 A.2d 744, 747, n.5 [D.C. Ct. App.]; Gundy v. Pauley, 619 S.W.2d 730, 731 [Ky.]; Rogers v. Commissioner of Dept. of Mental Health, 390 Mass. 489, 458 N.E.2d 308, 314; Matter of K.K.B., 609 P.2d 747, 749 [Okla.]; see, also, Sengstack v. Sengstack, 4 N.Y.2d 502, 176 (N.Y.S.2d 337, 151 N.E.2d 887; Finch v. Goldstein, 245 N.Y. 300, 157 N.E. 146. But see, Stensvad v. Reivitz, 601 F. Supp. 128 [Wis.]. See, Therapeutic Orgy, op. ct., 72 N.W.U.L. Rev., at 488, and authorities cited therein; Note, A Common Law Remedy For Forcible Mediation of the Institutionalized Mentally Ill, 82 Colum. L. Rev. 1720, 1722, n.20; Constitutional Right, op. cit., 8 Bull. of Am. Academy of Psychiatry & L., at 195-195; Bonnie, The Psychiatric Patient's Right to Refuse Medication: A Survey of the Legal Issues, at 19, 22, printed in Refusing Treatment in Mental Health Institutions--Values in Conflict; Cole, Patients' Rights v. Doctors' Rights:

principle that recognizes suicide as a basic human right. Therefore, it is contended that the criminal penalties that most states maintain against assisting suicide violate the right of privacy contained in the fourteenth amendment. This claim essentially incorporates John Stuart Mill's view that the only purpose for which power can rightfully be exercised over any member of a civilized community against his will is to prevent harm to others.[158] However, the United States Supreme Court has not identified the right of privacy with the pure analogy advocated by Mill.[159]

In Roe v. Wade,[160] noting that in connection with the abortion decision "a State may properly assert important interests in safeguarding health, [and] in maintaining medical standards,"[161] the Court remarked, ". . . [i]t is not

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[158] Lochner v. New York, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting). The comparison is made in P. Brest, Processes of Constitutional Decisionmaking 798 (1975). See In re Caulk, 480 A.2d 93, 99-100 (N.H. 1984) (Douglas, J., dissenting) (In support of upholding a constitutional right to starve oneself to death, Justice Douglas relies upon a quotation from J. Mill, On Liberty).

[159] See, Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973).

[160] 410 U.S. 113 (1973).

[161] Id. at 154. These are interests an autonomy theorist would certainly regard as paternalistic. Indeed, such is the basis of the criticism of Roe in Erickson, Woman and the Supreme Court: Anatomy is Destiny, 41 Brooklyn L. Rev. 209 (1974).

clear to us that the claim asserted by some . . . . that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions."[162] Evidently, the Court did not consider the basis for the right to privacy to be autonomy.

Perhaps the most explicit theoretical formulation of the right to privacy given by the Supreme Court was articulated in Whalen v. Roe:[163]

> The cases sometimes characterized as protecting "privacy" have in fact involved at least two different kinds of interests. One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions.[164]

Relevant in this context, of course, is the second interest: "independence in making certain kinds of important decisions."[165] As noted by the Whalen court, "[in] Paul v. Davis . . . the Court characterized these decisions as dealing with 'matters relating to marriage, procreation, contraception, family relationships, and child rearing and education.'"[166]

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[162] Id.

[163] 429 U.S. 589 (1977).

[164] Id. at 598-600 (citations omitted).

[165] Id. at 599-600.

[166] Id. at 600 n.26, (quoting Paul v. Davis, 424 U.S. 693, 713 (1976)).

In Roe v. Wade, the Court, apparently gleaning a determinative principle from its previous decisions concerning the right to privacy, held, "[t]hese decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' . . . are included in this guarantee of personal privacy."[167] In Griswold v. Connecticut,[168] the first Supreme Court case to explicitly enunciate a "right of privacy," Justice Goldberg, joined in his concurrence by two other members of the Court, stated:

> In determining which rights are fundamental, judges are not left at large to decide cases in light of their personal and private notions. Rather, they must look to the "traditions and [collective] conscience of our people" to determine whether a principle is "so rooted [there] . . . as to be ranked as fundamental.[169]

Is suicide a constitutionally protected liberty, "so rooted in the traditions and conscious of our people as to be ranked fundamental"?[170] I do not believe so. Do not the

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[167] Roe, 410 U.S. at 152 (quoting Palko v. Connecticut, 302 U.S. 319, 325 (1937)).

[168] 381 U.S. 479 (1965) (Goldberg, J., concurring).

[169] Id. at 493 (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934)). See, Moore v. City of East Cleveland, 431 U.S. 494 (1971), Meyer v. Nebraska, 262 U.S. 390 (1923).

[170] Snyder v. Massachusetts, 291 U.S. 97, 105 (1934). See also Wisconsin v. Yoder, 406 U.S. 205 (1972) where the Court, recognizing the right of Amish parents to keep their children out of school, concluded that its holding was supported by the "strong tradition" in "[t]he history and culture of Western civilization . . ." of deferring to parental decisionmaking concerning

states have, under certain circumstances, superior interests (as discussed in IV B, infra)? The great theorist Mill stated that

> . . . everyone who receives the protection of society owes a return for the benefit . . . in each person's bearing his share . . . of the labors and sacrifices incurred for defending society or its members . . . [W]hen a person disables himself . . . he is guilty of a social offense. No action so thoroughly disables a person from making a proper contribution to society as the suicide which renders that person forever incapable of any contribution.[171]

IV. THE CURRENT STATUS OF THE LAW OF THE STATE OF NEW YORK

A. Clear and Convincing Evidence Doctrine of Comatose or Terminally Ill Patients

Clearly the law's, or for that matter society's, attitudes have not been able to keep pace with the phenomenal developments in modern science. Although the right of a competent patient to refuse medical treatment has long been recognized, the right of a comatose patient first received

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childrearing, an attitude the Court found "established beyond debate as an enduring American tradition." Wisconsin v. Yoder, 406 U.S. 205, 232 (1972). Another example of the Court taking a historical approach to establish the content of constitutional rights can be found in Moore v. City of East Cleveland, where the plurality stated, "Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition," and accordingly invalidated a zoning ordinance that prohibited an extended family from living in the same house. 431 U.S. 494, 503, 506 (1977).

[171] Mill, On Liberty, at 302-303, 306.

national attention in 1975 with the case of Karen Quinlan,[172] in which the parents of the comatose individual sought the court's permission to remove their comatose daughter from a respirator.[173]

New York's encounter with this moral dilemma did not come until 1981 with the Brother Fox case,[174] in which Judge Wachtler restated the rule in New York concerning a competent patient's wishes.[175] The doctrine was reiterated in People v. Robbins,[176] where it was determined that criminal liability could not be imposed upon a spouse for failure to summon medical aid for his wife, a competent adult who decided to stop taking all medication for her epileptic and diabetic conditions. The Court stated the rule as follows:

> It would be an unwarranted extension of the spousal duty of care to impose criminal liability for failure to summon medical aid for a competent adult spouse who has made a rational decision to eschew medical assistance. In New York such a rationale would be in direct conflict with the related rule that a competent adult has a right to determine

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[172] In re Quinlan, 70 N.J. 647, 355 A.2d 647 (N.J. 1976).

[173] Id. at 651.

[174] 52 N.Y.2d 363, 420 N.E.2d 64, 438, N.Y.S.2d 266 (1981), cert. denied, 454 U.S. 858 (1981).

[175] Id. See supra page 43.

[176] 83 A.D.2d 271, 275, 443 N.Y.S.2d 1016, 1018-19 (4th Dep't 1981).

whether or not to undergo medical treatment (citations omitted).[177]

Similarly, it has been stated that ". . . it is the individual who is the subject of a medical decision who has the final say and that this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires".[178] In this regard, one United States District Court, in considering whether the terminally ill had a right to elect unconventional methods of treatment such as the use of the drug Laetrile, held that it was "uncontrovertible that a patient has a right to refuse cancer treatment altogether".[179]

In this regard, we will now examine the holdings in In Re Eichner[180] and Storar.[181] Without going into the in-depth

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[177] Id.

[178] Matter of Erickson v. Dilgard, 44 Misc. 2d 27, 28, 252 N.Y.S.2d 705, 706 (1962)

[179] Rutherford v. United States, 438 F. Supp. 1287, 1299, remanded, 582 F.2d 1234, rev'd, 442 U.S. 544, 99 S. Ct. 2470, 61 L. Ed.2d 68; accord, Union Pacific Ry. Co. v. Botsford, 141 U.S. 250, 251, 11 St. Ct. 1000, 1001, 35 L. Ed. 734; Matter of Melideo, 88 Misc. 2d 974, 975, 390 N.Y.S.2d 523, 524 [Lazer, J.]; Long Island Jewish-Hillside Med. Center v. Levitt, 73 Misc. 2d 395, 397, 342 N.Y.S.2d 356, 359; Matter of Nemser, 51 Misc. 2d 616, 273 N.Y.S.2d 624; Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d at p. 424, supra; Lane v. Candura, Mass. App., 376 N.E.2d 1232, 1236; Matter of Osborne, 294 A.2d 372 [D.C.]; Matter of Estate of Brooks, 32 Ill.2d 361, 205 N.E.2d 435; Matter of Yetter, 62 Pa. D. & C.2d 619; see, also, Note, "Last Rights": Hawaii's Law on the Right to Choice of Therapy for Dying Patients, 1 Hawaii L. Rev. 144, 153-157; Note, The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State, 51 N.Y.U. L. Rev. 285, 306-308; Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L. Rev. 1, 2-16.

[180] 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64.

details of the facts of the case,[182] Brother Fox was a comatose patient, who before he lapsed into that state, firmly indicated that the extraordinary measures used in Quinlan[183] should not be used to further his existence.[184] On the other hand, John Storar was profoundly retarded with a mental age of about 18 months.[185] In 1979 he was diagnosed as having cancer of the bladder which was terminal. The hospital administrator wished to administer blood transfusions claiming death would occur within weeks without them.[186]

In determining the type of proof the court should consider in helping it to reach a conclusion, the court reaffirmed that:

> Clear and convincing proof should be required in cases where it is claimed that a person, now incompetent, left instructions to terminate life sustaining procedures when there is no hope of recovery. This standard serves to "impress the factfinder with the importance of the decision" [187]

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[181] Id.

[182] For facts of Eichner, see supra pages 12-13.

[183] 137 N.J. Super 227, 348 A.2d 801, modified, 70 N.J. 10.

[184] Storar at 372, 438 N.Y.S.2d at 270, 420 N.E.2d at 68.

[185] Id. at 373, 438 N.Y.S.2d at 270, 420 N.E.2d at 68.

[186] Id. at 373-74, 438 N.Y.S.2d at 271, 420 N.E.2d at 69.

[187] Id. at 379, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274, (1981), citing Addington v. Texas, 441 U.S. 418, 427 (1979). This standard "forbids relief whenever the evidence is loose, equivocal or contradictory" Backer Mgt. Corp. v. Acme Quilting Co., 46 N.Y.2d 211, 220, 385 N.E.2d 1062, 413 N.Y.S.2d 135 (1978).

The court concluded that the evidence clearly and convincingly showed that Brother Fox did not want to be maintained in a vegetative coma by use of a respirator.[188] However, in the Storar case, John Storar was never competent at any time in his life. He was always totally incapable of understanding or making a reasoned decision about medical treatment.[189] Under these facts, the court concluded as follows:

> . . . [T]he application for permission to continue the transfusions should have been granted. Although we understand and respect his mother's despair, as we respect the beliefs of those who oppose transfusions on religious grounds, a court should not in the circumstances of this case allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that it is best for one with an incurable disease.[190]

The decision by the Court of Appeals in the Eichner and Storar cases clearly rejected the many arguments stated in the appellate division's exhaustive and wide ranging opinion.[191] It was established that, as a matter of constitutional law, a competent adult who is incurably and terminally ill has the right, if he so chooses, not to resist

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[188] Id. at 371, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

[189] Id. at 374, 420 N.E.2d at 69, 438 N.Y.S.2d at 271.

[190] Id. at 381-82, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

[191] See generally, In re Storar 78 A.D.2d 1013, 434 N.Y.S.2d 46; Eichner v. Dillon 73 A.D.2d 431, 426 N.Y.S.2d 517 (2d Dept. 1980).

death and to die with dignity.[192] Further, the court refused to promulgate elaborate procedural directives for future right-to-die cases.[193] Finally, while confining itself only to comatose patients with no hope of recovery and to terminally ill patients, the court refused to permit substituted judgment in cases like Storar.[194]

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[192] In re Storar, 52 N.Y.2d at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273 (1981).

[193] Id. at 382-83, 420 N.E.2d at 74, 438 N.Y.S.2d at 276 (1981).

[194] Id. See, Supt. of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) where the court adopted the doctrine of "substituted judgment" to determine the patient's wants and needs. See also In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981)(Jones, J., dissenting); In Re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); Brophy v. New England Sinai Hospital, 398 Mass. 417, 497 N.E.2d 626 (1986)

As Judge Burke noted in his dissenting opinion in Byrn v. New York City Health & Hospitals Corp., 31 N.Y.2d 194, 335 N.Y.S.2d 390 (1972), fundamental principles of constitutional law, natural law and even Biblical law should be borne in mind at all times when it concerns life. Our Fifth and Fourteenth Amendments to the Federal Constitution provide for a constitutional right for all persons to live, as does the Declaration of Independence. These documents did not create "new" rights, but were based on natural law, which dates back to the Magna Carta, and then to Judean Law created at the time of Moses. Id. at 208, 335 N.Y.S.2d at 399 (Burke, J., dissenting). The following passage is illustrative:

> The most basic of these rights is the right to live, especially in the case of the 'unwanted' who are defenseless. The late Chief Judge Lehman once wrote of these rights: 'The Constitution is misread by those who say that these rights are created by the Constitution. The men who wrote the Constitution did not doubt that these rights existed before the nation was created and are dedicated by God's word. By the Constitution, these rights were placed beyond the power of government to destroy.' In other words, what the Chief Judge was saying was that the American concept of a natural law binding upon government and

> citizens alike, to which all positive law must conform, leads back through John Marshal to Edmond Burke and Henry DeBracton and even beyond the Magna Carta to Judean Law. Human beings are not really creatures of the state, and by reason of that fact, our laws should protect the (right to life) from those who would take his life for purposes of comfort, convenience, property or peace of mind, rather than sanction his demise.

Id. at 205-206, 335 N.Y.S.2d at 397 (Burke, J., dissenting).

Thus, with great prescience, Judge Burke wrote that no law could constitutionally be enacted which would "do away with old folks and eliminate the great expense of the aged to the taxpayers. This, of course, would parallel the Hitler laws which decreed the death of all the inmates of mental hospitals and also decreed that for many purposes non-Aryans were non-persons". Id. at 208, 335 N.Y.S.2d at 399. Judge Scileppi joined with Judge Burke in that case in writing that it would be unconstitutional for "the child, weary of the burden of an aged and infirm father or mother, (to) condemn the parent to death" Id. at 214, 335 N.Y.S.2d at 404. See, also, Justice Cardamone's dissenting opinion in Matter of Storar, 78 A.D.2d 1013, 434 N.Y.S.2d 46, 47-48 (4th Dep't 1980) (later reversed), in which he wrote that to terminate blood transfusions for John Storar, a mentally retarded, terminally ill individual, would be "moral nonsense because to judicially order treatment terminated is antithetical to the moral precepts which underlie the common law. Courts should refrain from the temptation to be judicially active in this type of case involving such momentous moral issues . . . . . The circumstances here transcend mere statutory and constitutional views and lead inexorably back to the Author of the natural law from whose foundation all law is derived. The imperative of the Fifth Commandment - Thou shalt not kill - is reflected in the beginnings of the common law."Id. at 1013-14, 434 N.Y.S.2d at 47-48 (Cardamone, J., dissenting).

Many writers have also warned of the historic consequences of euthanasia. Derr, in "Why Food and Fluids Can Never Be Denied," notes that in Germany, between 1919 and 1935, before the Nazis rose to power, German physicians euthanasized more than 200,000 disabled adults and children in German hospitals, nursing homes and asylums. This program was originally advocated by a distinguished German psychiatrist, and law professor, Hoche and Binding, in Permitting the Destruction of Unworthy Life (1920). (See, also, Alexander, Leo, "Medical Science Under Dictatorship," New England Journal of Medicine (July 14, 1949).) Judge Burke, in Byrn, supra, also warned of this recent history. This Court should be conscious of this history, and, as numerous judges and commentators have asked, act cautiously.

It is interesting to note that in the case In Re Beth Israel Medical Center,[195] Justice Parness in a lower court ruling deviated from the holding in Eichner and used a "best interest" analysis.[196] He concluded that the court of appeals did not intend such a restrictive interpretation.[197] The court then listed some of the factors which should be considered in arriving at a decision.[198] This case was the first in New York in which medical treatment was withheld in the absence of what a court considered clear and convincing evidence of the

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[195] 136 Misc.2d 931, 519 N.Y.S.2d 511 (Sup. Ct. 1987)(court refused to order emergency amputation of leg of elderly stroke victim).

[196] Id. at 938, 579 N.Y.S.2d at 516.

[197] Id. at 937, 519 N.Y.S. at 515.

[198] Id. at 940, 519 N.Y.S. at 517. The factors enumerated were:

> 1. the age of the patient; 2. the life expectancy with or without the procedure contemplated; 3. the degree of present or future pain or suffering, without the procedure; 4. the extent of the patient's physical and mental disability and helplessness; 5. statements, if any, made by the patient which directly or impliedly manifest his views on life-prolonging measures; 6. the quality of the patient's life with or without the procedure, i.e., the extent, if any, of pleasure, emotional enjoyment or intellectual satisfaction that the patient will obtain from prolonged life; 7. the risks to life from the procedure contemplated as well as its adverse side effects and degree of invasiveness; 8. religious or ethical beliefs of the patient; 9. views of those to him; 10. view of the physician; 11. the type of care which will be will required if life is prolonged as contrasted with what will be actually available to him; 12. whether there are any overriding State parens patriae interests in sustaining life (e.g., preventing suicide, integrity of the medical profession or protection of innocent third parties, such as children).

patient's wishes. It was the first New York case to refuse to order life-sustaining treatment for an incompetent patient who had some minimum level of awareness.[199] This determination differed from another recent decision, In re Application of Kerr,[200] in which the court ordered surgery despite the existence of a living will which stated the patients wishes to the contrary.[201]

In the case of Matter of Westchester County Medical Center on Behalf of Mary O'Connor v. Hall,[202] the court reiterated that it utilizes the "clear and convincing evidence standard."[203] It stated that this standard requires that "the trier of fact must be convinced, as far as humanly possible, that the strength of the individual's beliefs and the durability of the individual's commitment to these beliefs makes a recent change of heart unlikely."[204] The court went on to say that the ideal situation for proof would be in the form of a "living will."[205] Such a writing would suggest

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[199] Id. at 942, 519 N.Y.S.2d at 518.

[200] Essner, No. 21748/86 (N.Y. Sup. Ct. Bronx County, Dec. 17, 1986) (Turret, J.)

[201] Id.

[202] 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

[203] Id. at 529, 531 N.E.2d at 612, 534 N.Y.S.2d at 891.

[204] Id. at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

[205] Id. at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

"the author's seriousness of purpose."[206] Furthermore, it was noted that a person who has expressly set forth his wishes in writing, would also make sure "that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends."[207] This was the first time the court of appeals acknowledged a "living will" but it did so in the form of acceptable evidence to be used with the clear and convincing evidence doctrine. However, the court once again reaffirmed its belief that it would be unrealistic to attempt to establish a rigid set of guidelines to be used in all cases.[208] Therefore it stated that a determination could only be made on case-by-case analysis.[209]

We now turn to the question of "whether the common law right to decline medical treatment . . . encompasses a right to remove or withhold artificial means of nourishment and hydration to an individual in a persistent vegetative

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[206] Id. 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

[207] Id. at 531, 531 N.E.2d at 613-614, 534 N.Y.S.2d at 892-893.

[208] Id. at 529, 531 N.E.2d at 612, 534 N.Y.S.2d at 891.

[209] Id. at 529, 531 N.E.2d at 612-613, 534 N.Y.S.2d at 891-892. See generally, Saunders v. State, 129 Misc.2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985)(description of living wills); In Re Lydia Hall Hospital, 116 Misc.2d 477, 455 N.Y.S.2d 706 (Sup. Ct. 1982)(clear and convincing evidence standard); Evans v. Bellevue Hospital, N.J.L.J., July 28, 1987, p. 11, Col. 1 (N.Y. Sup. Ct.)(living will rejected on grounds it lacked specificity); Elbaum v. Grace Plaza of Great Neck, 148 A.D.2d 244, 544 N.Y.S.2d 840 (2nd Dept. 1989) (clear and convincing evidence.)

state with no hope of recovery."[210] In Delio[211] the court held that in "the absence of specific legislation" they would have to analyze the moral, ethical, philosophical, social and legal problems in order to make an informed decision.[212]

Courts of other states have also addressed the controversial issue of when artificial nutrition and hydration devices could be withheld and have refused to differentiate between the various artificial devices available to sustain the life of a patient in a persistent vegetative state. The leading New Jersey decision in Matter of Conroy,[213] is instructive. With this case, the New Jersey supreme court became the first to uphold a case in which the patient himself authorized the removal of an artificial feeding tube. In addition, the court permitted a "substituted judgment" to be made on behalf of an incompetent person.[214] In so doing, the court modified the Quinlan case and set up future tests for withholding or withdrawing life sustaining treatment from elderly incompetent nursing home patients who would probably die within a year, even with treatment. These tests were known as the subjective test,

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[210] Delio v. Westchester County Medical Center, 129 A.D.2d 1, 2, 516 N.Y.S.2d 677, 679 (2d Dept. 1987).

[211] Id.

[212] Id. at 5, 516 N.Y.S.2d at 680.

[213] 98 N.J. 321, 486 A.2d 1209 (1985).

[214] Id. at 339, 486 A.2d at 1227.

the limited objective test and the pure objective test.[215] The court declared that life-sustaining treatment, including nourishment and hydration by artificial means, may be withheld from incompetent, institutionalized, elderly patients with severe and permanent mental and physical impairments and a limited life expectancy.[216] Because the New Jersey court restricted its holding to nursing home residents its precedential value is, concededly, somewhat limited.

In addition, the Supreme Court of New Jersey found that the distinction between extraordinary and ordinary types of treatment was not meaningful because of the various conflicting meanings the terms had assumed.[217] In finding that feeding by artificial means was equivalent to breathing by means of a respirator, the court opined that any distinction

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[215] These procedures were later modified in Matter of Peter by Johnanning, 108 N.J. 365, 366, 529 A.2d 419, 425 (1987); accord, Barber v. Superior Court, 147 Cal. App.3d 1006, 1017, 195 Cal. Rptr. 484, 491 (Ca. App. 2 Dist. 1983) ("physician has no duty to continue treatment once it has proved to be ineffective"); Bartling v. Superior Court, 163 Cal. App.3d 189, 194-94, 209 Cal. Rptr. 220, 224 (Ca. App. 2 Dist. 1984)(competent person whose condition was not terminal petitioned the Court to remove himself from a respirator. The court upheld the right of a person to disconnect life support system was not limited to comatose or terminally ill patients); Bouvia v. Superior Court, 179 Cal. App.3d 1127, 1139, 225 Cal. Rptr. 297, 302 (Cal. App. 2 Dist. 1986)(quoting Scholendroff v. Society of New York Hosp., 211 N.Y. 125, 126, 105 N.E. 92, 93); Satz v. Perlmutter, 362 So.2d 160, 169 (Fla. Dist. Ct. App. 1978), aff'd, 379 So.2d 359 (Fla. 1980); In re Welfare of Colyer, 99 Wash. 2d 114, 116, 660 P.2d 738, 742 (1980); Fosmire v. Nicoleau, 75 N.Y.2d 218, 226, 551 N.E.2d 77, 81, 551 N.Y.S.2d 876, 880 (1990).

[216] Id. at 322.

[217] Id. at 323.

drawn was more psychologically compelling because of the emotional symbolism of food than it was logically sound.[218] The recent decision of the Supreme Court of Massachusetts in Brophy v. New England Sinai Hosp.,[219] adopted the reasoning of the New Jersey court in Conroy.[220]

The Court in Delio,[221] after reviewing decisions in other jurisdictions and failing to uncover a single case in which a court confronted with an application to discontinue feeding by artificial means, evaluated medical procedures to provide nutrition and hydration differently from other types of life-sustaining procedures.[222] They concluded that the ultimate decision to refuse treatment is for the patient alone to reach, thus enabling the patient to "live out his life in dignity and peace for whatever period of time remains."[223] The courts should, in the absence of

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[218] Id. at 324.

[219] 398 Mass. 417, 497 N.E.2d 626 (1986).

[220] Id. at 636-37. See also, In re Workmen's Circle Home and Infirmary for the Aged v. Fink, 135 Misc.2d 270, 273, 514 N.Y.S.2d 893 (In a recent decision of the Supreme Court, Bronx County, Justice Tompkins distinguished between passive medical treatment which he refused to permit to be discontinued and active medical treatment which, in accordance with the clearly expressed wishes of the patient prior to the onset of the chronic vegetative state held could properly be refused).

[221] In re Delio v. Westchester County Med. Center, 129 A.D.2d 1, 516 N.Y.S.2d 677, (2d Dept. 1987).

[222] Id. See, Barber v. Superior Court for Los Angeles County, 147 Cal. App.2d 1006, 1017, 195 Cal. Rptr. 484, 490; In re Conroy, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985).

[223] Delio, supra, at 22, 516 N.Y.S.2d at 691.

countervailing State interests, honor the patient's wishes.

B. State Interests

As stated in Eichner and Storar, ". . . [w]e recognize that under certain circumstances the common law right [for a competent adult to determine what should be done to his own body] may have to yield to superior State interests, as it would even if it were constitutionally based . . ."[224]

Implicit in this balancing is the axiom that the common-law right to refuse medical treatment is not absolute and may, in some cases, yield to a "countervailing" State interest.[225] Courts and commentators have commonly identified four compelling State interests in medical treatment decisions: (1) the preservation of life; (2) the prevention of suicide; (3) the protection of innocent third parties; and (4) the maintenance of the ethical integrity of the medical profession.[226]

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[224] In re Storar, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 77, 438 N.Y.S.2d 2666, 273 (1981), cert. denied, 454 U.S. 858 (1981)

[225] Id. at 465-467, 426 N.Y.S.2d 543-44.

[226] Id. See also, Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 432, 497 N.E.2d 636, 634 (1986); In re Conroy, 98 N.J. 321, 373, 486 A.2d 1209, 1223 (1985); Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809, 814-15; Siegal, In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment, 6 Pace L. Rev. 219, 224-227 (1986); Merritt, Equality for the elderly Incompetent: A Proposal for a Dignified Death, 39 Stan. L. Rev. 689, 702-704 (1987); Calabrese, In re Storar: The Right to Die and Incompetent Patients, 43 U. Pitt. L. Rev. 1087, 1092 (1982).

Therefore, let us examine the state's interests in religious refusal cases and mentally incompetent cases and under what circumstances the State of New York will or will not assert its power of parens patriae.

1. Religious Refusal Cases

The right to refuse medical treatment may be overridden by countervailing compelling state interests. Thus, for example, an individual may not refuse to be vaccinated where his refusal presents a threat to the community at large.[227]

The state's interest in preserving life is commonly considered the most significant of the four state interests listed above.[228] In balancing the state's interest against the individual's right not to be kept alive in a chronic vegetative state, "the State's interest . . . weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims".[229] The dilemma faced by the courts on applications to discontinue treatment of a person in a chronic vegetative state was expressed in

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[227] See, Jacobson v. Massachusetts, 197 U.S. 11, 39.

[228] See, e.g., Matter of Eichner [Fox], 73 A.D.2d 431, 426 N.Y.S.2d 517; Matter of Brophy, 398 Mass. 417, 497 N.E.2d 626; Matter of Conroy, 98 N.J. 321, 486 A.2d 1209.

[229] Matter of Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664; see, also, Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 134, 482 A.2d 713, 718; Matter of Spring, 380 Mass. 629, 405 N.E.2d 115, 119; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 740, 370 N.E.2d 417, 425-426.

the opinion in Matter of Eichner [Fox].[230] The court found upon those facts that the desire of Brother Fox to die with dignity outweighed the State interest in the preservation of life, reasoning that:

> . . . [T]he patient in a permanent vegetative coma has no hope of recovery and merely lies, trapped in a technological limbo, awaiting the inevitable. As a matter of established fact, such a patient has no health and, in the true sense, no life, for the State to protect. Thus, the use of a respirator, or any other extraordinary means of life support, under these circumstances, does not serve to advance the State's interest in protecting health or life.[231]

In conjunction with the State's interest in preserving life, the State has a particular interest in preventing suicide. However, suicide requires a specific intent to die which has generally been found lacking in patients who refuse artificial life-sustaining medical treatment.[232] Instead, a person's desire to have artificial life-support systems terminated evinces only an intent to live free of unwanted mechanical devices and permit the

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[230] Eichner at 465, 426 N.Y.S.2d at 543.

[231] Id. Emphasis in original.

[232] See, e.g., Matter of Eichner [Fox], supra, at 467, 426 N.Y.S.2d at 543; Matter of Conroy, 98 N.J. 321, 350-351, 486 A.2d 209, 1224; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, n.11; Matter of Colyer, 99 Wash. 2d 114, 123, 660 P.2d 738, 743.

processes of nature to run their course.[233]

The third asserted State interest in overriding a patient's right to refuse medical treatment is the interest in protecting innocent third parties, particularly minor children, and is rooted in the concept of parens patriae.[234] The State's interest may well be superior to an adult's right of self-determination when the exercise of that right deprives dependents of a source of support and care.[235] The interests of the State are also strongly implicated where the patient is responsible for the support of minor children and where refusal to accept treatment threatens to bring about

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[233] See, e.g., Matter of Eichner [Fox] at 467, 426 N.Y.S.2d 517; Matter of Brophy, 398 Mass. 417, 439, 497 N.E.2d 626, 638; Matter of Conroy, 98 N.J. 321, 350-351, 486 A.2d 1209, 1224; Satz v. Perlmutter, 362 So.2d 160, 162.

In Matter of Vogel, 134 Misc. 2d 395, 512 N.Y.S.2d 622, Justice Robbins of Nassau County Supreme Court refused to allow removal of a gastric nasal tube from a comatose patient with no hope of recovery. The court concluded that allowing removal would be tantamount to an embrace of "sympathetic euthanasia" by permitting the patient to starve to death.

Compare the Matter of Von Holden v. Chapman, 87 A.D.2d 66, 450 N.Y.S.2d 623, where the court upheld the right of a state psychiatric facility to force feed an inmate on a hunger strike in furtherance of the State's interest in preventing suicide. In this case, the inmate was suffering from no infirmity and was not declining life-sustaining treatment necessary because of a natural degenerative condition. Under these circumstances, the inmate's refusal to eat constituted an attempt to commit suicide.

[234] See, Siegal, In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment, 6 Pace L. Rev. 219, 225 (1986).

[235] In re Eichner [Fox], 73 A.D.2d 431, 466, 426 N.Y.S.2d 517, 544 (2d Dept. 1980); In re Conroy, 98 N.J. 321, 353, 486 A.2d 1209, 12235; Leach v. Akron Gen. Med. Center, 68 Ohio Misc. 1, 426 N.E.2d 809, 814 (1980).

their "abandonment."[236]

The fourth and final State interest asserted as a limitation on a patient's right of self-determination is the interest in safeguarding the ethical integrity of the medical profession. This interest has largely been overcome or at least lessened by the prevailing medical ethical standards which do not require medical intervention at all costs.[237]

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[236] Application of President & Directors of Georgetown Coll. Inc., 331 F.2d 1000, 1008, (D.C. Cir. 1964)(treatment was ordered over the refusal of the 25 year old mother of a seven month old child), cert. denied 377 U.S. 978 (1964).

[237] In re Storar, 52 N.Y.2d 363, 385, 438 N.Y.S.2d 266, 277-78, 420 N.E.2d 64, 75-77 (1981); In re Conroy, 98 N.J. 321, 351, 486 A.2d 1209, 1224-1225; Siegal, In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment, Pace L. Rev. 219, 226 (1986); see generally, Brohpy v. New England Sinai Hospital, Inc., 398 Mass. 417, 439, 497 N.E.2d 626, 638 ([I]t is not unethical to discontinue all means of life-prolonging medical treatment"(quoting the AMA Council on Ethical and Judicial Affairs (1986))). The AMA position is as follows:

> Statement of the Council on Ethical and Judicial Affairs
>
> WITHHOLDING OR WITHDRAWING
> LIFE PROLONGING MEDICAL TREATMENT
>
> The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice of an authorized proxy, the physician must act in the best interest of the patient.
>
> For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the

The Brophy[238] court also observed that directing the discontinuance of life-sustaining medical treatment would not intrude upon a hospital's ethical integrity if the court were to refrain from directly forcing a hospital to affirmatively act to terminate the life-sustaining treatment.[239] Further, the State has a compelling interest in maintaining the ethical integrity of the medical profession by protecting physicians against the compelled violation of their professional standards and against exposure to the risk of

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physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment.

Life prolonging treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.

[238] 398 Mass. 417, 440, 497 N.E.2d 626, 638-39.

[239] Id.

civil or criminal liability.[240]

Lastly, it has long been recognized that the State has an interest in discouraging irrational and wanton acts of self-destruction which violate fundamental norms of society.[241]

In Powell v. Columbia Presbyterian Medical Center,[242] a Jehovah's Witness refused to sign authorization for blood transfusion on religious grounds. The court found that the patient did not object to treatment, but only that she would not direct its use.[243] In In re Jamaica Hospital,[244] a Jehovah's Witness in critical condition with an 18 week old fetus refused medical treatment on religious grounds. The court concluded that the fetus could be regarded as a human being to whom the court stood in parens patriae and ordered all necessary medical treatment, including blood

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[240] See, e.g., Application of President & Directors of Georgetown Coll., supra; United States v. George, 239 F. Supp. 752 (O. Conn. 1965); Byrne, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L. Rev. 1, 29-33 (1976).

[241] See, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. at 243, n. 11, 370 S.E.2d at 426, n.11; In re President & Directors of Georgetown College, 331 F.2d at 1008-09; Annas, Reconciliating Quinlan and Saikewicz: Decision Making for the Terminally Ill Incompetent, 4 Amer. J. L. & Med. 367, 373-374, n.19 (1978); Note, Suicide and the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases, 44 Brooklyn L. Rev. 285; Byrn, supra note 240 (citing, inter alia, Hales v. Petit, 75 Eng. Rep. 387 (1562).

[242] 49 Misc. 2d 215, 267 N.Y.S..2d 450 (Sup. Ct. 1965).

[243] Id. at 216, 267 N.Y.S.2d at 451.

[244] 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985).

transfusions.[245]

In Crouse-Irving Hospital v. Paddock,[246] the supreme court recognized that the state's compelling interest in the welfare of children "will override even the parents' most fervently held religious beliefs."[247]

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[245] Id. at 1008, 491 N.Y.S.2d at 900. Accord Crouse-Irving Hosp. v. Paddock, 127 Misc. 2d 101, 103, 485 N.Y.S.2d 443, 445 (Sup. Ct. 1985); In Re Winthrop Univ. Hosp. v. Hess, 128 Misc. 2d 804, 805, 490 N.Y.S.2d 996, 997 (Sup. Ct. 1985); In re Melideo, 88 Misc. 2d 974, 975, 390 N.Y.S.2d 523, 524 (Sup. Ct. 1976).

[246] 127 Misc. 101, 485 N.Y.S.2d 443 (Sup. Ct. 1985).

[247] Id. at 102-103, 485 N.Y.S.2d at 444-45. The court then reviewed the state's various interests as follows:

> A parent or guardian has a right to consent to medical treatment on behalf of an infant (Public Health Law, § 2504, subd. 2). The parent may not deprive a child of lifesaving treatment however well intentioned. (Matter of Sampson, 29 N.Y.2d 900 [328 N.Y.S.2d 686, 278 N.E.2d 918]; Matter of Vasko, 238 App. Div. 128 [263 N.Y.S. 552]; Matter of Santos v. Goldstein, 16 A.D.2d 755 [227 N.Y.S.2d 450], mot. for lv. to app. dsmd., 12 N.Y.2d 642 [232 N.Y.S.2d 1026, 185 N.E.2d 551]; cf. Matter of Hofbauer, 47 N.Y.2d 648 [419 N.Y.S.2d 936, 393 N.E.2d 1009]). Even when the parents' decision to decline necessary treatment is based on constitutional grounds, such as religious beliefs, it must yield to the State's interests, as parens patriae in protecting the health and welfare of the child (Matter of Sampson, supra; Jehovah's Witnesses v. King County Hosp. Unit, 390 U.. 598 [88 S. Ct. 1260, 20 L. Ed.2d 158], aff'g, 278 F. Supp. 488; People ex rel. Wallace v. Labrenz, 411 Ill. 618 [104 N.E.2d 769], cert. den., 344 U.S. 824 [73 S. Ct. 24, 97 L. Ed. 642]; Power of Public Authorities to Order Medical Care for A Child Over Objection of Parent or Guardian, Ann., 30 ALR 2d 1138; cf. Prince v. Massachusetts, 321 U.S. 158 [64 S. Ct. 438, 88 L. Ed. 645]. Of course it is not for the courts to determine the most 'effective' treatment when the parents have chosen among reasonable alternatives (Matter of Hofbauer, 47 N.Y.2d 648 [419 N.Y.S.2d 936, 393 N.E.2d 1009], supra). But the courts may not permit a parent to deny a child all treatment for a condition which threatens his life (compare Custody of A Minor, 375 Mass. 733 [379 N.E.2d 1053], with Matter of Hofbauer, supra, p. 656 [419 N.Y.S.2d 936, 393 N.E.2d

In In Re Erickson,[248] the patient was willing to undergo an operation but refused blood transfusion.[249] The court declined to order the transfusion on the grounds that he was a fully competent person, capable of making this decision himself.[250] This case was cited in Eichner[251] and Rivers v. Katz[252] as support for a common law right to refuse life-sustaining treatment.[253]

2. Mentally Incompetent Cases

Interest in the preservation of life, coupled with its responsibility to act as parens patriae for minors or incompetents, may sometimes require that treatment be accepted.

Actually, the question is composed of two separate elements: (1) do the courts have the adjudicatory power to

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1009]). The case of a child who may bleed to death because of the parents' refusal to authorize a blood transfusion presents the classic example (Jehovah's Witnesses v. Kings County Hosp., supra; Matter of Sampson, supra). Matter of Storar, 52 N.Y.2d 363 at 381-382, 438 N.Y.S.2d 266, 420 N.E.2d 64.

[248] 44 Misc. 2d 227, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

[249] Id. at 27-28, 252 N.Y.S.2d at 706.

[250] Id. at 28, 252 N.Y.S.2d at 706.

[251] 73 A.D.2d 431, 455, 426 N.Y.S.2d 517, 536 (2 Dept., 1980).

[252] 67 N.Y.2d 485, 493, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74, 78(1986).

[253] See, In Re Worker's Circle v. Fink, 135 Misc. 2d 270, 272-73, 514 N.Y.S.2d 893, 895 (Sup. Ct. 1987); see also, In Re Harris v. Roberts, 91 A.D.2d 1141, 458 N.Y.S.2d 719, (3rd Dep't 1987).

act; and if they do, (2) should that power be exercised in these cases absent legislation. There is no doubt that the court has the power to entertain and adjudicate these cases. The State has a legitimate interest in asserting its parens patriae powers over the mentally incompetent, both to provide care and to safeguard the best interests of those who are physically unable to care for themselves.[254]

If we turn our attention to the substantive legal problems, we recognize that, while the right of a competent patient to refuse medical treatment is uncontroverted, by contrast the right of an incompetent patient to refuse medical treatment or to have it withdrawn may be subject to some controversy.

Rivers v. Katz,[255] was a consolidated action in which three involuntarily committed patients at the Harlem Valley Psychiatric Center refused antipsychotic medication. They brought suit to enjoin the hospital from administering the antipsychotic drugs without their consent and for a

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[254] See Addington v. Texas, 441 U.S. 418, 426, 99 S. Ct. 1804, 1809, 60 L. Ed.2d 323; O'Connor v. Donaldson, 422 U.S. 563, 575, 95 S. Ct. 2486, 2493, 45 L. Ed.2d 396; Matter of Lublin v. Central Islip Psychiatric Center, 43 N.Y.2d 341, 345, 401 N.Y.S.2d 466, 469, 372 N.E.2d 307, 310; Matter of Weberlist, 79 Misc. 2d 753, 756, 360 N.Y.S.2d 783, 786; Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d at p. 427, supra; Note, The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State, 51 N.Y.U.L. Rev. 285, 309; Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 444 Fordham L. Rev. 1, 24.

[255] 67 N.Y.2d 485, 504 N.Y.S.2d 74, 495 N.E.2d 337 (1986).

declaration of their rights.[256] The Court of Appeals upheld the right of refusal, stating:

> . . . neither mental illness nor institutionalization per se can stand as a justification for overriding an individual's fundamental right to refuse antipsychotic medication on either police power or parens patriae grounds. Rather, due process requires that a court balance the individual's liberty interest against the State's asserted compelling need on the facts of each case to determine whether such medication may be forcibly administered.[257]

Thus, a balancing test is required when an incompetent wishes to refuse medical treatment. The balancing test differs with the state interest involved. When exercising its police power, as when a patient is a danger to himself or others, (e.g., in an emergency situation) the state is justified in imposing medication only so long as the emergency lasts. Even here, however, the state's interest must be compelling in order to override the patient's liberty interest in control of his care and treatment.[258]

When exercising its parens patriae power, the court must first determine that the patient "lacks the capacity to decide for himself whether he should take the drugs."[259] If the court concludes that he lacks such capacity, the proposed

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[256] Id. at 495, 504 N.Y.S.2d at 80, 495 N.E.2d at 343.

[257] Id. at 498.

[258] Id. at 495-96.

[259] Id. at 496.

treatment must be narrowly tailored so as "to give substantive effect to the patient's liberty interest, taking into consideration all relevant circumstances."[260]

C. Families' Role in Decision Making

The New York courts have strongly affirmed the rights of families as proxy decision makers where no statute applied.[261]

Long Island Jewish-Hillside Medical Center v. Levitt,[262] the court endorsed the importance of family involvement as an integral part of the decision making process. In responding to a hospital request for court authorization to perform surgery on a patient who was, in the opinion of the doctors, incapable of making a decision regarding his own health, the New York Supreme Court, Nassau County, acknowledged its duty to act in this circumstance.[263] The testimony revealed that

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[260] Id. at 497.

[261] See In Re Barbara C., 116 Misc.2d 31, 455 N.Y.S.2d 182, (Sup. Ct. 1982), aff'd., 101 A.D.2d 137, 474 N.Y.S.2d 799 (1984). The court was required to apply New York statutes under the Penal Law (defining when an abortion is justifiable) and the Mental Hygiene Law (providing particularized care to institutionalized individuals and requiring consent to surgery). Id. at 32, 455 N.Y.S.2d at 183. Cf. New York City Health & Hosp. Corp. v. Stein, 70 Misc. 2d 944, 335 N.Y.S.2d 461, (Sup. Ct. 1972). The court interpreted a recodification of the Mental Hygiene Law which did not specify whose consent was required for administration of shock treatment: "[T]he new statute presumably requires . . . the consent of the closest relative or guardian . . . or, where necessary, of the Court [if the patient is incapacitated]." Id. at 945, 335 N.Y.S.2d at 463 (citations omitted).

[262] 73 Misc.2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973).

[263] Id. at 357, 342 N.Y.S.2d at 359.

the hospital petitioned the court because "to their knowledge . . . there was no one competent or willing to give consent"[264] at that time, since the only relative the patient had identified, his sister, refused to make the decision.[265] However, upon further inquiry, a niece was located and appointed as her uncle's guardian for the purpose of giving consent to the operation.[266]

The final approach to decisionmaking for incompetent non-terminally ill patients involving the courts in non-life threatening situations when the family cannot agree on a course of action, is strongly disapproved of by the courts. In re Nemser[267] illustrates this type of case.

In Nemser, proceedings were initiated by two sons of a patient to be appointed guardians for the limited purpose of consenting to amputation of their mother's foot, a procedure opposed by a third son.[268] The court confronted the conflicts that arise for health care personnel, the issues of the nature and scope of judicial power, and the appropriateness of judicial intervention.[269] Because the patient was considered incapable of understanding her

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[264] Id. at 358.

[265] Id. at 361.

[266] Id.

[267] 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966).

[268] Id. at 618.

[269] Id. at 619.

situation, the physicians would not operate without the consent of the patient's next-of-kin.[270] Since one son refused to agree, the other sons initiated court proceedings.[271] The customary practice of health care professionals to rely initially on consent of family members when patients are unable to act responsibly on their own behalf is thus demonstrated.[272] In addition, it demonstrates that, when disagreement arises among the next-of-kin, the parties will seek recourse to the courts, whereas otherwise they would not.[273]

In Nemser, the court concluded that judicial intervention could not be justified, since the patient had neither been adjudicated incompetent nor was she a minor who

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[270] Id. at 620.

[271] Id. at 620.

[272] See In re Storar, 52 N.Y.2d 363,385, 420 N.E.2d 64, 75, 438 N.Y.S.2d 266, 277 (1981) (Jones, J., dissenting in part) cert. denied, 454 U.S. 858 (1982). Judge Jones stated: "There is reliable information that for many years physicians and members of patients' families, often in consultation with religious counselors, have in actuality been making decisions to withhold or withdraw life support procedures from incurably ill patients incapable of making the critical decisions for themselves." Id. (Footnote omitted). In a footnote to this statement, Justice Jones discussed professional attitudes toward euthanasia and a policy statement of the American Medical Association recognizing that the stoppage of extraordinary life-prolonging treatment where there is unrefuted evidence that death is imminent should be a decision of the patient and/or his immediate family. Id. at 385-86 n. 3, 420 NM.E.2d at 75-76, n.3, 438 N.Y.S.2d at 277-78 n.3.

[273] See Nemser, 51 Misc.2d at 617-20, 273 N.Y.S.2d at 625-27.

was statutorily treated as a ward of the court.[274] The court was critical of the demand by the physicians for legal immunity to perform necessary life-sustaining treatments.[275]

The court further opined that courts should not condone such action by assuming jurisdiction under these circumstances, and that hospitals and physicians in conjunction with the family should be forced to assume the responsibility for making these medical decisions. The court explained its position in these terms:

> Is the court to be made the arbiter in all family disputes as to the wisdom or necessity of medical treatment, or is that, in reality, a medical problem to be resolved by the physician, his patient, where possible, and the family, if necessary?[276]

V. ETHICAL POSITIONS

As stated by Judge Burke in the Byrn decision,[277]

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[274] Id. at 620-21, 273 N.Y.S.2d at 628. The two sons were not seeking appointment at their mother's committee. Id. at 621, 273 N.Y.S.2d at 628. They only requested appointment as temporary legal representatives for the limited purpose of consenting to the proposed amputation. Id.

[275] Id. at 621-22, 273 N.Y.S.2d at 629 (declaring that "the current practice of members of the medical profession . . . [is to shift] the burden of their responsibilities to the courts . . . .") (emphasis added). Id. at 622, 273 N.Y.S.2d at 629.

[276] Id. For additional cases on this topic see In Re Barbara C., 116 Misc. 2d 31, 455 N.Y.S.2d 182 (1982), aff'd, 101 A.D.2d 137, 474 N.Y.S.2d 799 (1984); Anonymous v. State, 17 A.D.2d 495, 236 N.Y.S.2d 88 (1963). For a thorough review on the three approaches of the role of the family in decisionmaking see, Krasik, The Role of the Family in Medical Decision Making for Incompetent Adult Patients: A Historical Perspective and Case Analysis, 48 U. Pitt. L. Rev. 539.

[277] Byrn cite, at p. 397.

human beings are not creatures of the state and by reason of that fact, our laws should protect the right to life from those who would take his life for purposes of comfort, convenience, property or peace of mind, rather than sanction his demise.[278]

Is the main focus in the Right-To-Die cases the "quality of life" rather than the "sanctity of human life"? Does not the law which embodies social policy inevitably reflect moral judgment to some degree? Is not our law based upon Judeo-Christian principles? If clear and convincing evidence of a person's intent is the rule in New York, then an individual's religious beliefs may be relevant to that extent. Accordingly, we shall deal with the Catholic and Jewish positions.

A. Heroic Measures to Prolong Dying - Ethical Considerations

There is a great confusion between euthanasia and sound medical practice. One writer states that the sound medical care of the dying patient lies somewhere between mercy killing and the inexcusable prolongation of death and suffering.[279] He further says that it is sound medical practice, not positive or negative euthanasia, to discontinue

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[278] Byrn cite, at 397.

[279] C.P. Harrison, "Euthanasia, Medicine, and the Law," Canadian Medical Association Journal 113 (1975): 833-834.

treatment that no longer affects the patient's disease and to use pain-relieving measures in adequate amount. He also believes that it is not the physician's right to decide when a patient should die. The physician is not obligated to keep the patient alive or to kill him, but to treat his terminal illness as best he can. How crude to assert: "The earlier he is killed, the more pain he is spared, the easier it is on the physician and relatives, and the less the cost of hospitalization. Why keep the patient alive when there are so many advantages of killing him?" The suffering patient may well ask for death, but it is relief from mental and physical suffering that he seeks, not death.

It has been bluntly stated that in the last twentieth century, "most Americans can expect to go through the tortures of the damned before they are allowed to die of cancer, heart or lung failure, or pure senile decay."[280] Everyone would agree that the process of dying should be as pleasant as possible. Many patients prefer the warm surroundings of their own homes in the last days of their lives. They feel more secure and "more in control of forces acting on them in their dependent state than they would in the hospital."[281] Patients need to feel dignified enough during their dying to participate in decision-making and to

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[280]W. Dock, Dysthanasia: The Lot of the Shackled Sick," New York State Journal of Medicine 75 (1975): 842.

[281]M.J. Krant, "The Patient Who Wants to Die at Home," Journal of the American Medical Association 234 (1975): 1068.

feel esteemed enough to interact supportively with their family and friends.[282]

Often, however, dying occurs in the lonely, mechanical, dehumanized atmosphere of the hospital rather than the privacy of one's own home, surrounded by friends and family. The physician should perhaps make "terminal illness rounds" just as he makes medical or surgical or chart rounds. Such rounds would not solve all the moral dilemmas surrounding death and dying, including the physician's reactions to dying patients.[283] The new technology denies the physician a simple physiological end point for death. When is a donor dead, so that his organs can be removed for organ transplantation? It is ethical to infuse mannitol into a patient dying of head injury to preserve his kidneys for grafting? Dare we remove kidneys from a donor whose heart is still beating? Is it "cruel" in the presence of a fatal disease, in the agonal hours, to prolong life (or death) by the use of machines?

Does the age of a patient play a role in the decision whether to use "ordinary" or "extraordinary" (to be defined below) measures to prolong life? The medical definitions of "ordinary" and "extraordinary" are different

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[282]M.J. Krant, "Dying: A Meaningful Summation of Life," Medical Insight 5 (1973): 27-29.

[283]E. Kubler-Ross, S. Wessler, and L.V. Avioli, "On Death and Dying," Journal of the American Medical Association 221 (1972): 174-179.

from those of the ethicist. To the latter, the terms are relative and depend on time, place, and situation circumstances. How does one approach a five-year-old child with terminal acute leukemia? Is an eighty-year-old man with terminal prostatic cancer to be treated differently from the child with leukemia?

What should be done and what should not be done for a terminally ill patient? Who is to weigh the value of a few more days of life? Who is to decide when the end should come? The physician? The patient? Should the decision be put upon the family? Should the patient have the option to choose a peaceful death without exposure to the seemingly relentless application of medical technology? Should one discuss this option with the patient? The basic question seems to be the extent to which any individual owns his own death. Does a person have the right to select how and when he will die? Is such a decision by the patient akin to suicide? What is an individual's responsibility to his life and health? Judeo-Christian teaching is that life is a gift of God to be held in trust. One is duty bound to care for one's life and health. Only God gives life, and hence only God can take it away. This individual responsibility for the preservation of one's life and health is apart from the duty of one person (including a physician) toward another's life and health and society's responsibility concerning the life and health of its citizens.

Not only have man's birth and death moved from his home to the hospital, but the physician has often replaced the clergyman. Many terminal patients lack religious faith, yet they desperately need emotional support; but by whom? The busy physician? The busy nurse? Many physicians shy away from dying patients. Is the hospital, during this era of advanced technology, a place where illness and organs, rather than people, are treated? The emotional support and reassurance to the dying patient are usually provided by the family and clergy where appropriate, in addition to the medical team.

The doctor-patient relationship is no longer what it used to be because of a variety of factors. There are legal forces, such as the medical malpractice issue, that may interfere with the physician's best clinical and ethical judgment. There are psychological forces pushing the physician to "do something." There are professional forces that may force a physician to act to protect himself from peer review. Patients are better informed and becoming more vocal. The physician's own religious and ethical values, his own experiences, his teachings by preceptors all play a role in deciding how he approaches a dying patient. Factors such as the values of the medical profession in general, the expectations of the patient, the family, and the institution where the patient is hospitalized may also modify the physician's decision to use or not to use "heroic measures,"

however one defines that phrase. Ultimately, to whom is the physician responsible? To himself? To the patient? To society? Or to God?

Should the care of the dying be no different from that of any patient? One must always consider the therapeutic goal. One goal may be appropriate to the disease and another appropriate to the patient. For some diseases, such as tuberculosis, the goals are identical, i.e., eradicate the disease, thus curing the patient. Even if the disease cannot be cured, food, analgesics, and good nursing care can and should be given. It is often easy to treat the disease purely medically. It is much harder to treat the patient as a person with a disease. In a terminally ill patient, penicillin may be considered by the ethicist but not by the physician to be "extraordinary" treatment. Yet the physician may not administer the penicillin because the goal may not be to cure the pneumonia in an incurably ill cancer patient.

The terms "heroic" and "extraordinary" will be discussed further later. It is indeed unfortunate that confusing and ambiguous slogans such as "Death with Dignity,"[284] "Beneficent Euthanasia,"[285] and "Quality of Life"[286]

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[284]P. Ramsay, "The Indignity of 'Death and Dignity,'" Hastings Center Report 2 (1974): 47-62.

[285]M. Kohl, Beneficent Euthanasia (Buffalo: Prometheus Books, 1975).

have emerged. The promotion of death with dignity is but one manifestation of what appears to be a current literary obsession with death in both lay and professional writings.[287] There has even developed a backlash against medical ethics;[288] a major lecture during the 1975 annual session of the American College of Physicians was entitled "The Unethical in Medical Ethics."[289] One writer even went so far as to assert that "the most inflated non-issue currently absorbing time and energy in the health community and its governmental command posts is the loose amalgamation of anxieties and passions that comes under the banner of medical ethics."[290]

Be that as it may, the physician at the bedside of a critically or terminally ill patient is faced with moral and ethical dilemmas to which there are no easy solutions. Need everything be done to prolong life at all costs? Should patients be spared painful and expensive therapy by the cessation or non-application of such therapy? Is it

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[286]J.K. Luce, and J.J. Dawson, Quality of Life," Seminars in Oncology 2 (1975): 323-327; W.B. Patterson, "The Quality of Survival in Response to Treatment," Journal of the American Medical Association 233 (1975): 280-281.

[287]F.J. Ingelfinger, "Empty Slogan for the Dying," New England Journal of Medicine 291 (1974): 845-846.

[288]K.D. Clouser, "Medical Ethics: Some Uses, Abuses, and Limitations," New England Journal of Medicine 293 (1975): 384-387.

[289]F.J. Ingelfinger, "The Unethical in Medical Ethics," Annals of Internal Medicine 83 (1975): 264-269.

[290]D.S. Greenberg, "Ethics and Nonsense," New England Journal of Medicine 290 (1974): 977-978.

ethically permitted to intervene actively to terminate life?[291]

VI. CONCLUSION

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[291]S.I. Spector, "The End of Days: The Jewish Concept of Death," Omega 5 (1974); Jakobovits, "Medical Experimentation on Humans in Jewish Law," in Jewish Bioethics, ed. F. Rosner and J.D. Bleich (New York: Hebrew Publishing Co., 1979); I. Jakobovits, Jewish Medical Ethics (New York: Bloch, 1959); Y. Levi, "That Which Prevents the Departure of the Soul," Noam 16 (1963): G.A. Rabinowitz and M. Koenigsberg, "The Halachic Definition of Death in the Light of Medical Knowledge," Hadarom, No. 32 (Tishri 5731 [197]): A. Steinberg, "Establishing the Moment of Death," Noam 19 (1977): A.S. Abraham, "Treatment of a Gosses and the Determination of Death," Halachah Urefuah 2 (1981): M.D. Tendler, "Cessation of Brain Function: Ethical Implications in Terminal Care and Organ Transplants," Annals of the New York Academy of Sciences 315 (1978); A. Soloveichik, "The Halakhic Definition of Death," in Jewish Bioethics, ed. F. Rosner and J.D. Bleich. (New York: Hebrew Publishing Co., 1979); Rema on Shulchan Aruch, Yoreh Deah 339:1; Eger, Commentary Gilyon Maharsha on Shulchan Aruch, Yoreh Deah, 339:1; Jacob ben Samuel, Responsa Bet Yaakov, no. 59; J. Reischer, Responsa Shevut Yaakow, pt. 3, no. 13; I. Jakobovits, "The Dying and Their Treatment in Jewish Law: Preparation for Death and Euthanasia," Hebrew Medical Journal 2 (1961): 251 ff. See also idem, Jewish Medical Ethics (New York: Bloch, 1959); J.D. Bleich, "Establishing Criteria of Death," in Contemporary Halakhic Problems (New York: Ktav, 1977); J.D. Bleich, "Time of Death Legislation," Tradition 16 (1977).

Sacred Congregation for the Doctrine of the Faith - Declaration of Euthanasia: Adopted by the Sacred Congregation for the Doctrine of the Faith: Approval by Pope John Paul II; Released to the Public June 26, 1980; Declaration on Procured Abortion, 18 November 1974; AAS 66 (1974); Pius XII, Address to those attending the Congress of the International Union of Catholic Women's Leagues, 11 September 1947; AAS 39 (1947); Address to the Italian Catholic Union of Midwives, 29 October 1951: AAS 43 (1951), Speech to the members of the International Office of military medicine documentation, 19 October 1953: AAS 415 (1953), Address to those taking part in the IXth Congress of the Italian Anesthesiological Society, 24 February 1957: AAS 49 (1957); cf. also Address on "reanimation" 24 November 1957: AAS 49 (1957), Paul VI, Address to the members of the United Nations Special Committee on Apartheid, 22 May 1974: AAS 66 (1974), John Paul II: Address to the Bishops of the United States of America, 5 October 1979: AAS 71; One thinks especially of Recommendation 779 (1976) on the rights of the sick and dying, of the Parliamentary Assembly of the Council of Europe at its XXVIIth Ordinary Session; cf. SIPECA, No. 1, March 1977.

Man does not possess absolute title to his life or to his body. Man is charged with preserving, dignifying, and hallowing that life. The modern phrases "quality of life" and "quality of existence" embody within them a concept of worthiness with connotations of personal character and social status.

Should a decision as to whether life is worth living be determined on the basis of pain, suffering, and, as some today suggest, from a consideration if its deviancy from normal? When a person's intellect ceases to function because he is in coma, that person is intellectually dead. When a person cannot function in society because he is mentally deficient or physically malformed, he is socially dead. Should such individuals not be allowed to live because they lack "worthiness"?

Emotional and financial burdens are frequently cited as justification for decisions about "heroic" measures or life-support systems for a defective infant, a vegetative adult, or a terminally ill cancer patient. Social costs should remain divorced from such decision-making. The public should rightly assume the fiscal burden associated with maintaining incompetent patients such as Karen Ann Quinlan whose lives are being preserved.

Suffering of the family is another reason offered for allowing a patient such as Karen Ann Quinlan to die by

removing artificial life supports. Precisely because of their closeness to the situation, the family is not capable of reaching a detached, dispassionate, and objective decision. On this basis, the sanctity of life as a preeminent value is being threatened. Evil has small beginnings. When the quality of life replaces the sanctity of life, society has done itself irreparable harm.

VII. SURVEY OF LAWS OUTSIDE NEW YORK STATE AS OF APRIL, 1991

Right-to-die Case and Statutory Citations State-by-State Listing

Alabama
Alabama Natural Death Act [1981], Ala. Code Sec. 22-8A-1 to -10(1990). Camp v. White, 510 So.2d 166 (Ala. 1987).

Alaska
Alaska Rights of Terminally Ill Act [1986], Alaska Stat. Sec. 18.12.010 to -.100 (Supp. 1990). Alaska Statutory Form Power of Attorney Act [1988], Alaska Stat. Sec. 13.26.332 to 13.26.353 (Supp. 1990).

Arizona
Arizona Medical Treatment Decision Act [1985], Ariz. Rev. Stat. Ann. Sec. 36-3201 to -3210 (1986). Arizona Powers of Attorney Act [1974], Ariz. Rev. Stat. Ann. Sec. 14-5501 to -5502 (Supp. 1989), as interpreted by Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987). Lurie v. Samaritan Health Service, No. C510198 (Ariz. Super. Ct. Maricopa County March 24, 1984). Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987).

Arkansas
Arkansas Rights of the Terminally Ill or Permanently Unconscious Act [1987], Ark. Code Ann. Sec. 20-17-201 to -218 (Supp. 1989).

California
California Natural Death Act [1976], Cal. Health & Safety Code Sec. 7185 to 7195 (West Supp. 1989). California

Statutory Form Durable Power of Attorney for Health Care Act [1984, 1985,1988, 1990], Cal. Civil Code Sec. 2430 to 2444 (West Supp. 1990 & A.B. 835, ch. 331, July 18, 1990). Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (Ct. App. 1983). Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 97, 228 Cal. Rptr. 847 (Ct. App. 1986), on remand, No. 500735 (Cal. Super. Ct. Los Angeles County Oct. 14, 1987) (attorney fees) (Riley, J.). Bartling v. Glendale Adventist Medical Center, 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (Ct. App. 1986) (damages). Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Ct. App. 1984). Bouvia v. Glenchur, 195 Cal. App. 3d 1075, 241 Cal.Rptr. 239 (Ct. App. 1987) (attorney fees). Bouvia v. County of Riverside, No. 159780 (Cal. Super. Ct. Riverside County Dec. 16, 1983) (Hews, J.). Bouvia v. Superior Court (Glenchur), 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Ct. App. 1986), review denied (Cal. June 5, 1986). Cantor v. Weiss, No. 626163 (Cal. Super. Ct. Los Angeles county Dec. 30, 1986) (Newman, J.). Childs v. Abrahamovice (Morrison), 206 Cal. App. 3d 304, 253 Cal. Rptr. 530, 88 Daily Journal D.A.R. 14963 (Cal.Ct. App. 1988)(King, J.). In re Cruse, No. J914410 (Cal. Super. Ct. Los Angeles County Feb. 15, 1979) (Byrne, J.). In re Conservatorship of Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1938), cert. denied, 102 L.Ed. 2d 387,109 S. Ct. 399 (1988), rehearing denied, 102 L.Ed. 2d 816, 109 S. Ct. 828 (1989). Foster v. Tourtellotte, No. CV 81-5046-RMT (C.D. Cal. Nov. 16, 17, 1981), connected case, 704 F.2d 1109 (9th Cir. 1983). Gary v. California (Hirth), No. 576 123 (Cal. Super. Ct. San Diego County March 5, 23), modified in part (April 15, 1987) (Milkes, J.). Gary v. Superior Court, No. D006166 (Cal. Ct. App. 4th Dist. Sept. 25, 1987) (Kremer, J.). Sanchez v. Fairview Developmental Center, No. CV 88-0129 FFF(Tx) (C.D. Cal. March 30, 1988) (Fernandez, J.), 4 Issues in L. & Med. 129; connected case, No. 563-313 (Cal. Super. Ct. Orange County Sept. 2, 1988) (McDonald, J.). Westhart v. Mule, 213 Cal. App. 3d 542, 261 Cal. Rptr. 640, 89 Daily Journal D.A.R. 10903 (Ct. App. 1989) (Bauer, J.). In re Young, No. A 100863 (Cal. Super. Ct. Orange County Sept. 11, 1979) (Sumner, J.).

Colorado

Colorado Medical Treatment Decision Act [1985, 1989], Colo. Rev. Stat. Sec. 15-18-101 to -113 (1987 & Supp. 1990). Colorado Powers of Attorney Act [1963], Colo. Rev. Stat. Sec. 15-14-501 to -502 (1987), as interpreted by In re Rodas, No. 86PR139 (Colo. Dist. Ct. Mesa County Jan. 22, 1987, as modified, April 3, 1987) (Buss, J.). In re Rodas, No. 86PR139 (Colo. Dist. Ct. Mesa County Jan. 22, 1987, as modified, April 3, 1987) (Buss, J.). Ross v. Hilltop Rehabilitation Hospital, 676 F. Supp. 1528 (D. Colo. 1987) (Rodas damage claim).

Connecticut

Connecticut Removal of Life Support Systems Act [1985]. Conn. Gen. Stat. Sec. 19a-570 to -575 (Supp. 1989). Connecticut Statutory Short Form Durable Power of Attorney Act, Pub. Act 90-71 (H.B. 5117, signed May 4, 1990). Foody v. Manchester Memorial Hospital, 40 Conn. Supp. 127, 482 A.2d 713 (Super. Ct. 1984). McConnell v. Beverly Enterprises, 209 Conn. 692, 553 A.2d 596 (1989).

Delaware

Delaware Death with Dignity Act [1982, 1983], Del. Code Ann. tit. 16, Sec. 2501 to 2509 (1983). In re Severns, 425 A.2d 156 (Del. Ch. 1980). Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980). In re Shumosic, No. 5515 (Del. Ch. Sept. 27, 1988) (Allen, C.).

District of Columbia

District of Columbia Natural Death Act of 1981 [1982], D.C. Code Ann. Sec. 6-2421 to -2430 (Supp. 1989). District of Columbia Health-Care Decisions Act of 1988 [1988]. D.C. Code Ann. Sec. 21-2201 to -2213 (1989). In re A.C., 573 A.2d 1235 (D.C. Ct. App. 1990). Tune v. Walter Reed Army Medical Hospital, 602 F. Supp. 1452 (D.D.C. 1985).

Florida

Florida Life-Prolonging Procedure Act [1984, 1985, 1990], Fla. Stat. Ann. Sec. 765.01 to -.15 (1986 & H.B. 513 enacted without signature June 30, 1990). Florida Durable Power of Attorney Act [1974, 1977, 1983, 1988, 1990], Fla. Stat. Ann. Sec. 709.08 (Supp. 1990); Health Care Surrogate Act, Fla. Stat. Ann. Sec. 745.41 to -.52 (Supp. 1990). In re Guardianship of Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) (Scheb, J.). In re Guardianship of Browning, 568 So. 2d 4 (1990). Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App.), review denied, 492 So. 2d 1331 (Fla. 1986). Gilbert v. State, 487 So. 2d 1185 (Fla. Dist. Ct. App.), review denied 494 So. 2d 1150 (Fla. 1986). Helstron v. Florida Life Care, No. 88-1870-CA-01 (Fla. Cir. Ct. Sarasota County May 10, 1988) (Boylston, J.). Hoffmeister v. Coler, 544 So. 2d 1067 (Fla. Dist. Ct. App. 4th Dist. 1989) (attorney fees). Hoffmeister v. Satz, No. 87-28451 CR (Fla. Cir. Ct. 17th Dist. Broward County Feb. 22, 1988). John F. Kennedy Hospital, Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984). In re Baby Girl Muller, No. 88-1073 (Fla. Cir. Ct. Hillsborough County Feb. 9, 1988) (Evans, J.). Rekstad v. Florida Life Care, Inc., No. 87-4285-Ca-01 (Fla. Cir. Ct. Sarasota County Sept. 18, 1987) (Walker, J.). In re Guardianship of Rothblatt, No. 87-4256-41 (Fla. Cir. Ct. Penellas County Aug. 24, 1987) (Ward, J.). Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct.App. 1978), affirmed, 379 So. 2d 359 (Fla. 1980). In re Underwood, No. 85-8107-CA-T (Fla. Cir. Ct. Brevard County Aug. 30, 1985).

In re Zahn, No. 85-3723 Fla. Cir. Ct. Broward County Nov. 20, 1986) (Hare, J.).

Georgia

Georgia Living Wills Act [1984, 1986, 1987, 1989], Ga. Code Ann. Sec. 31-32-1 to -12 (1985 & Supp. 1989). Georgia Durable Power of Attorney for Health Care Act [1990], Ga. Code Sec. 31-36-1 to -13 (Supp. 1990). In re Jane Doe, No. D 56730 (Ga/ Super. Ct. Fulton County July 13, 1988) (Williams, J.). In re Jane Doe, No. D 62058 (Ga. Super. Ct. Fulton County Nov. 30, 1988) (Langham, J.). Kirby v. Spivey, 167 Ga. App. 751, 307 S.E.2d 538 (Ct. App. 1983). In re L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984). In re McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989). University Health Services, Inc. v. Piazzi, No. CV86-RCCV-464 (Ga. Super. Ct. Richmond County Aug. 4, 1986) (Fleming, J.). Young v. Emory University, No. 83-6143-5 (Ga. Super. Ct. Dekalb County Aug. 10, 29, 1983) (Fuller, J.). Zodin v. Manor Health Care, No. 9010821007 (Ga. Super. Ct. Cobb County Nov. 21, 1990) (White, J.).

Hawaii

Hawaii Medical Treatment Decisions Act [1986], Hawaii Rev. Stat. Sec. 327D-1 to -27 (Supp. 1988). Hawaii Uniform Durable Power of Attorney Act [1989], Hawaii Rev. Stat. Sec. 551D-1 to -7 (Supp. 1989), health care decisions authorized by Medical Treatment Decisions Act, Hawaii Rev. Stat. Sec. 237D-2 (Supp. 1988). In re Guardianship of Crabtree, No. 86-0031 (Hawaii Fam. Ct. 1st Cir. April 26, 1990) (Heeley, J.). Wilcox v. Hawaii, Civ. No. 860116 (Hawaii Cir. Ct. 5th Cir. June 16, 1986) (Hirano, J.).

Idaho

Idaho Natural Death Act [1977, 1986, 1988], Idaho Code Sec. 39-4501 to -4509 (1985 & Supp. 1989).

Illinois

Illinois Living Will Act [1984, 1988], Ill. Ann. Stat. ch. 110 1/2, Sec. 701 to 710 (Smith-Hurd Supp. 1989). Illinois Powers of Attorney for Health Care Act [1987, 1988] Ill. Ann. Stat. ch. 110 1/2 Sec. 804-1 to -11 (Smith-Hurd 1989). In re Greenspan, 137 Ill. 2d 1, 558 N.E.2d 1194, remanded, No. 88P8726 (Cir. Ct. Cook County Oct. 3, 1990) (Dowdle, J.). In re Estate of Longeway, 1133 Ill. 2d 33, 549 N.E. 2d 292 (1989). In re Estate of Prange, 166 Ill. App. 3d 1091, 520 N.E. 2d 946 (Ct. App.), vacated, 527 N.E.2d 303, cert. denied sub nom. Murphy v. Benson, 102 L. Ed.2d 219, 109 S.Ct. 229, 57 U.S.L.W. 3259 (1988).

Indiana

Indiana Living Wills and Life-Prolonging Procedures Act [1985], Ind. Code Ann. Sec. 16-8-11-1 to -22 (Burns Supp.

1989).

Iowa
Iowa Life-sustaining Procedures Act [1985, 1987], Iowa Code Ann. Sec. 144A.1 to -.11 (1989). Iowa Power of Attorney Act [1975], Iowa Code Sec. 633.705 to -706 (Supp. 1989), health care decisions authorized by Iowa Life-sustaining Procedures Act, Sec. 144A.7(a) (1989). Morgan v. Olds, 417 N.W. 2d 232 (Iowa Ct. App. 1987).

Kansas
Kansas Natural Death Act [1979], Kan. Stat. Ann. Sec. 65-28, 101 to -28, 109 (1985). Kansas Durable Power of Attorney for Health Care Decisions Act [1989], Kan. Stat. Ann. Sec. 58-625 to -632 (Supp. 1989).

Kentucky
Kentucky Living Will Act [1990], Ky. Rev. Stat. Sec. 311.622 to -.642 (Supp. 1990). Kentucky Health Care Surrogate Act [1990], Ky. Rev. Stat. Sec. 311.970 to -.986 (Supp. 1990).

Louisiana
Louisiana Life-Sustaining Procedures Act [1984, 1985, 1990], La. Rev. Stat. Ann. Sec. 40:1299.58.1 to -.10 (Supp. 1989 & S.B. 652, signed July 18, & H.B. 714, Signed July 29, 1990).

Maine
Maine Uniform Rights of the Terminally Ill Act [1985, 1990], Me. Rev. Stat. Ann. tit. 18-A, Sec. 5-701 to -714 (H.B. 1497 signed April 17, 1990). Maine Powers of Attorney Act [1986], Me. Rev. Stat. Ann. Tit. 18-A, Sec. 5-501 (Supp. 1989). In re Gardner, 534 A.2d 947 (Me. 1987). In re Hallock, No. 88381 (Me. P. Ct. Kennebec County Sept. 26, 1988) (Mitchel, J.). In re Swan, 569 A.2d 1202 (Me. 1990). In re Weaver, No. 89-177 (Me. P. Ct. Cumberland County Feb. 27, 1989) (Childs, J.); No. 89-177 (P. Ct. Cumberland County March 28, 1989) (Childs, J.) (Motion to Intervene and for Reconsideration denied).

Maryland
Maryland LIfe-Sustaining Procedures Act [1985, 1986, 1987], Md. Health-General Code Ann. Sec. 5-601 to -614 (Supp. 1988). Maryland Durable Power of Attorney Act [1969, 1974], Md. Est. & Trust Code Ann. Sec. 13-601 to -603 (1974), as interpreted by 73 Opinions of the Attorney General ____ [Opinion No. 88-046 (October 17, 1988)]; 75 Opinions of the Attorney General ____ [Opinion No. 90-044 (Sept. 24, 1990)]. In re Riddlemoser, No. 17 (Md. Ct. App. October 17, 1989).

Massachusetts
Massachusetts Health Care Proxy by Individuals Act, Mass. Gen. Laws. ch. 201D (H.B. 5906, signed Dec. 18, 1990).

Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E.2d 626 (1986). In re Dinnerstein, 6 Mass. App. 466, 380 N.E.2d 134 (Ct. App. 1978). In re Guardianship of Jane Doe, (Mass. P. and Fam. Ct. Norfolk Div. July 26, 1990). In re Hier, 18 Mass. App. 200, 464 N.E.2d 959 (Ct. App.), review denied, 392 Mass. 1102, 465 N.E.2d 261 (1984). In re Laws, No. 226215 (Mass. P. & Fam. Ct. Essex Div. May 4, 1987) (Buczko, J.). Custody of a Minor, (1) 375 Mass. 733, 379 N.E.2d 1053, 97 A.L.R.3d 401 (1978) (leukemia & chemotherapy); Custody of a Minor, (2) 378 Mass. 732, 393 N.E.2d 836 (1979) (related case involving leukemia, chemotherapy and laetrile). Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982) (No code). In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980). Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

Michigan

Michigan Power of Attorney for Health Care Act, Mich. comp. Laws, Sec. 496.1 to -.23 (H.B. 4016, signed December 18, 1990). In re Blodgett, No. 83-26514-AZ (Mich. Cir. Ct. Washtenaw County May 25, 1984) (Ager, J.). In re Culham, No. 87-340537-AZ (Mich. Cir. Ct. Oakland County Dec. 15, 1987) (Breck, J.). In re Hayes, No. 90-113, 811-GD (Mich. P. Ct. Macomb County Aug. 30, 1990) (Nowicki, J.). In re Rivlin, No. 89-369904-AZ (Mich. Cir. Ct. Oakland County July 18, 1989) (Gage, J.). In re Rosebush, No. 88-349180-AZ (Mich. Cir. Ct. Oakland County July 29, 1988) (Kuhn, J.), appeal filed, No. 111082 (Mich. Ct. App. 1990). In re Rosebush, No. 88-349180-AZ (Mich. Cir. Ct. Oakland County Nov. 30, 1988) (attorneys fees) (Kuhn, J.).

Minnesota

Minnesota Adult Health Care Decisions Act [1989], Minn. Stat. Sec. 145B.01 to -.17 (Supp. 1990). In re Welfare of Steinhaus (Minn. Redwood County Ct., Juv. Div. Sept. 11), reversed, (Redwood County Ct., Fam. Div. Oct. 13, 1986). In re Torres, 357 N.W.2d 332 (Minn. 1984).

Mississippi

Mississippi Withdrawal of Life-Saving Mechanisms Act [1984], Miss. Code Ann. Sec. 41-41-101 to -121 (Supp. 1988). Mississippi Durable Power of ATtorney for Health Care Act [1990], Miss. Coce Ann. Sec. 41-41-151 to -183 (Supp. 1990).

Missouri

Missouri Life Support Declarations Act [1985], Mo. Ann. Stat. Sec. 459.010 to -.055 (Vernon Supp. 1990). Cruzan v. Director, Missouri Department of Health, et al., 497 U.S. ____, 111 L. Ed.2d 224, 110 S. Ct. 2841 (1990). Cruzan v. Mouton, No. CV384-9P (Mo. Cir. Ct. Jasper County Dec. 14, 1990) (Teel, J.). Sullivan v. St. John's Mercy Medical

Center (Stoppe), No. 561631 (Mo. Cir. Ct. St. Louis County June 8, 1987) (Weinstock, J.).

Montana
Montana Living Will Act [1985, 1989], Mont. Code Ann. Sec. 50-9-101 to -104, -111, -201 to -206 (1987).

Nevada
Nevada Withholding or Withdrawal of Life-Sustaining Procedures Act [1977, 1985, 1987], Nev. Rev. Stat. Sec. 449.540 to -.690 (1986 & Supp. 1988). Nevada Durable Power of Attorney for Health Care Act [1987], Nev. Rev. Stat. Ann. Sec. 449.800 to -.860 (Supp. 1989). McKay v. Bergstedt, N. 21207 (NV Nov. 30, 1990).

New Hampshire
New Hampshire Terminal Care document Act [1985], N.H. Rev. Stat. Ann. Sec. 137-H:1 to -H:16 (Supp. 1988).

New Jersey
New Jersey Act [1972], N.J. Stat. Ann. Sec. 46:2B-8 (Supp. 1989), as interpreted by In re Peter, 108 N.J. 365, 529 A.2d 419 (1987). In re Clark, 210 N.J. Super. 548, 510 A.2d 136 (Super Ct. Ch. Div. 1986); 212 N.J. Super. 408, 515 A.2d 276 (Super Ct. Ch. Div. 1986), affirmed, 216 N.J. Super. 497, 524 A.2d 448 (Super. Ct. App. Div. 1987). In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). In re Farrell, 108 N.J. 335, 529 A.2d 404 (1987). In re Fields, (N.J. Super. Ct. Ch. Div. Salem County No. 6, 1986) (Miller, J.). Fuhrmann v. Kean, No. 86-1951 (D.N.J. July 13, 1987) (Cowen, J.). In re Jobes, 210 N.J. Super. 543, 510 A.2d 133 (Super. Ct. Ch. Div.), review denied (N.J. March 10, 1986). In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987). McVey v. Englewood Hospital Association, 216 N.J. Super. 502, 524 A.2d 450 (Super. Ct. App.Div.) (per curiam), certification denied, 108 N.J. 182, 528 A.2d 12 (1987). In re Moorhouse, No. 54178 (N.J. Super. Ct. Cumberland County Dec. 12, 1990) (Kleiner, J.). In re Peter, 108 N.J. 365, 529 A.2d 419 (1987). In re Putzer, No. P21-87E (N.J. super. Ct. Ch. Div. Essex County July 9, 1987) (Margolis, J.). In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922, 50 L.Ed. 2d 289, 97 S. Ct 319 (1976), diverged in part, In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). In re Requena, 213 N.J. Super. 475, 517 A.2d 886 (Super. Ct. Ch. Div.), affirmed, 213 N.J. Super. 443, 517 A.2d 869 (Super. Ct. App.Div. 1986) (per curiam). Strachan v. John F. Kennedy Memorial Hospital, 109 N.J. 523, 538 A.2d 346 (1988). In re Visbeck, 210 N.J. Super. 527, 510 A.2d 125 (Super. Ct. Ch. Div. 1986).

New Mexico
New Mexico Right to Die Act [1977, 1984], N.M. Stat. Ann.

Sec. 24-7-1 to -11 (1986). New Mexico Durable Power of Attorney Act [1989], N.M. Stat. Ann. Sec. 45-5-501 to -502 (Supp. 1989). New Mexico ex rel. Smith v. Fort, No. 14,768 (N.M. 1983).

New York

New York Health Care Proxy Act [1990], N.Y. Pub. Health Law Sec. 2980 to 2994 (S.B. 6176-A, signed July 22, 1990). In re Application of Alderson (Kimbrough), No. 90193/86 (N.Y. Sup. Ct. N.Y. County Aug. 3, 1988) (Ciparick, J.); N.Y. L.J. Aug. 9, 1988, at 18, col. 2. In re Beth Israel Medical Center (Weinstein), 136 Misc. 2d 931, 519 N.Y.S.2d 511 (Supp. Ct. N.Y. County 1987). In re Application of Brooks (Leguerrier) (N.Y. Sup. Ct. Albany County June 10, 1987) (Conway, J.). Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987). In re Petition of the Department of Veterans Affairs Medical Center, No. M-45 (S.D.N.Y. Aug. 17, 1990). In re Eichner (In re Storar), 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981). Elbaum v. Grace Plaza of Great Neck, 148 A.D.2d 244, 544 N.Y.S.2d 840 (2d Dep't 1989). Evans v. Bellevue Hospital (Wirth), No. 16536/87 (N.Y. Sup. Ct. N.Y. County July 27, 1987) (Sandifier, J.); N.Y.L.J. July 28,1987, at 11, col. 1. In re Finsterbach, (N.Y. Sup. Ct. Oneida County June 12, 1990) (Tenney, J.). In re Application of Gannon (Coons), No. 0189-017460 (N.Y. Sup.Ct. Albany County April 3), vacated, No. 0189-017460 (Sup. Ct. Albany County April 11, 1989). Grace Plaza of Great Neck v. Elbaum, No. 19068/88 (N.Y. Sup. Ct. Nassau County January 9, 1990) (McCabe, J.) (nursing home fees). In re Hallahan, No. 16338/1989 (N.Y. Sup. Ct. Bronx County Aug. 28, 1989). Hayner v. Child's Nursing Home,No. 0188 015609 (N.Y. Sup. Ct. Albany County Dec. 5, 1988) (McDermott, J.). In re Hofbauer, 47 N.Y.2d 648, 419 N.Y.S.2d 936, 393 N.E.2d 1009 (1979). In re Application of Kerr (O'Brien), 135 Misc. 2d 1076, 517 N.Y.S.2d 346 (Sup.Ct. N.Y. County 1986). In re Application of Kerr (Essner), No. 21748/86 (N.Y.Sup. Ct. Bronx County Dec. 17, 1986) (Turret, J.). In re Application of Kruczlnicki (Keyes), No. 26796 (N.Y. Sup. Ct. Warren County Feb. 16, 1989) (Dier, J.). In re Application of Licopoli (Akullian), No. 1172-88 (N.Y. Sup. Ct. Albany County March 10, 1988) (Prior, J.). In re Lydia E. Hall Hospital, 116 Misc. 2d 477, 455 N.Y.S. 2d 706 (Sup. Ct. Nassau County 1982); 117 Misc. 2d 1024, 459 N.Y.S.2d 682 (Sup. Ct. Nassau County 1982). Marie v. Astoria General Hospital, No. 03607/88 (N.Y. Sup. Ct. Queens County March 23, 1988) (Zelman, J.). In re Mazzarro, No. 90-14709 (N.Y. Sup. Ct. Suffolk County Jan. 2, 1991) (Gowan, J.). In re Moschella, No. 5806/84 (N.Y. Sup. Ct. Queens County May 10, 1984) (Kassoff, J.); N.Y.L.J. May 22, 1984, at 12, col. 2. In re Application of Plaza Health and Rehabilitation Center (N.Y.Sup. Ct. Onondaga County Feb. 2, 1984) (Miller, J.). In

re Ramos, No. 7715-90 (N.Y. Sup. Ct. Bronx County March 13, 1990) (Salmon, J.). Saunders v. State, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. Nassau County 1985). In re Stoara, 52 N.Y.2d 363, 420 N.E. 2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981). In re Strauss, No. 8378/87 (N.Y. Sup. Ct. Bronx County July 1, 1987) (Thompkins, J.). In re Triarsi, No. 86-14241 (N.Y. Sup. Ct. Suffolk County Aug. 21, 1986) (Yachnin, J.); N.Y.L.J. Sept. 18, 1986, at 12, col. 5. U.S.A. v. University Hospital, 575 F. Supp. 607 (D.N.Y. 1983), affirmed, 729 F.2d 144 (D.C. Cir. 1984). In re Vogel, 134 Misc. 2d 395, 512 N.Y.,S.2d 622 (Sup. Ct. Nassau County 1986), declined to follow in Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987). Weber v. Stony Brook Hospital, 95 App. Div. 2d 587, 467 N.Y.5.2d 685, affirmed, 60 N.Y.2d 208, 456, N.E.2d 1186 (1983). In re Weiland (Juchnewicz), No. 89-033 (N.Y. Sup. Ct. Suffolk County January 19, 1989) (Colby, J.). In re Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988). Wickel v. Spellman, 552 N.Y.S.2d 437 (App. Div. 2d Dep't 1990). Workmen's Circle Home and Infirmary for the Aged v. Fink, 135 Misc. 2d 270, 514 N.Y.S.2d 893 (Sup. Ct. Bronx County 1987), declined to follow in Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987).

North Carolina

North Carolina Right to Natural Death Act [1977, 1979, 1981, 1983], N.C. Gen. Stat. sec. 90-320 to -322 (1989). North Carolina Power of Attorney Act [1983], N.C. Stat. Sec. 32A-8 to -14 (1987).

North Dakota

North Dakota Uniform Rights of the Terminally Ill Act [1989], N.D. Cent. Code Sec. 23-06.4-01 to -14 (Supp. 1989). In re Bayer, No. 4131 (N.D. Burleigh County Ct. Feb. 5, 11 and Dec. 11, 1987) (Riskedahl, J.).

Ohio

Ohio Power of Attorney Act for Health Care [1989], Ohio Rev. Code Ann. Sec. 1337.11 to -.17 (Anderson 1989). Couture v. Couture, 48 Ohio App. 3d 208, 549 N.E.2d 571 (Ct. App. Montgomery County 1989). In re Guardianship of Dial, No. 333, 119 (Ohio Ct. Com. Pl. Prob. Div. Franklin County Feb. 26, 1985) (Metcalf, J.); Bloom v. Grant Hospital, No. 85 CV-02-1081 (Ohio Ct. Com. Pl. Franklin County Feb. 26), writ of mandamus dismissed sub nom. State of Ohio ex rel. Bloom, No. 85-332 (Dec. 4, 1985). Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (Com. Pl. 1980). Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (Ct. App. 1984). In re Milton, 29 Ohio St. 3d 20, 505 N.E.2d 255, cert. denied sub nom. Ohio Dep't Mental Health v. Milton, 484 U.S. 820, 98 L.Ed. 2d 41, 108 S. Ct. 79 (1987).

Oklahoma
Oklahoma Natural Death Act [1985, 1987, 1990]. Okla. Stat. Ann. tit. 63, Sec. 3101 to 3111 (1991). Oklahoma Hydration & Nutrition for Incompetent Patients Act [1987, 1990], Okla. Stat. Ann. tit. 63, Sec. 3080.1 to -.4 (1991).

Oregon
Oregon Rights with Respect to Terminal Illness Act [1977, 1983], Or. Rev. Stat. Sec. 127.605 to -.650 (1990). Oregon Durable Power of Attorney for Health Care Act [1989], Or. Rev. Stat. Sec. 127.505 to -.585 (1990). Evans v. District Attorney of Douglas County, No. E82-2173 (Or. Cir. Ct. Douglas County Dec. 13, 1982).

Pennsylvania
Pennsylvania Durable Powers of Attorney Act [1982], Pa. Stat. Ann. tit. 20, Sec. 5604 to 5607 (Supp. 1989). In re E.L.K. Incompetent, No. 72065 (Pa. Ct. Com. Pl. Orphan's Ct. Div. Berks County Jan. 18, 1991). In re Jane Doe, 16 Phila. 229 (Pa. Ct. Com. Pl. Philadelphia County 1987), Neugman Medical Center v. Popowich, No. 5663 (Pa. Ct. Com. Pl.1st Jud. Dist. April 26, 1990). Ragona v. Preate, No. 90 EQUITY 118 (Pa. Ct. Com. Pl. Lackawanna County Nov. 30, 1990).

Rhode Island
Rhode Island Health Care Power of Attorney Act [1986, 1989], R.I. Gen. Laws Sec. 23-4.10-1 to -2 (1989). Gary v. Romeo, 697 F. Supp. 580 (D.R.I. 1988). Gray v. Romeo, 709 F. Supp. 325 (D.R.I. 1989) (attorney fees).

South Carolina
South Carolina Death with Dignity Act [1986, 1988], S.C. Code Ann. Sec. 44-77-10 to -160 (Law. Co-op Supp. 1988). South Carolina Powers of Attorney Act [1986, 1990], S.C. Code Ann. Sec. 62-5-501 to -.502 (Law Co-op Supp. 1990).

South Dakota
South Dakota Living Will Act [1991], S.B. 210 (signed March 14, 1991). South Dakota Durable Powers of Attorney Act [1977, 1979, 1990], S.D. Codified Laws Ann. Sec. 59-7-2.1 to -2.8 (Supp. 1990).

Tennessee
Tennessee Right to Natural Death Act [1985], Tenn. Code Ann. Sec. 32-11-101 to -110 (Supp. 1988). Tennessee Durable Power of Attorney for Health Care [1990], Tenn. Code Ann. Sec. 34-6-101 to -214 (Supp. 1990). Jane Dow v. Wilson, No. 90-364-II (Tenn. Ch. Ct. Davidson County February 16, 1990) (High, Ch.).

Texas

Texas Natural Death Act [1977, 1979, 1983, 1985, 1990], Tex. Rev. Civ. Stat. Ann. Sec. 672.001 to -.021 (Vernon Supp. 1990). Texas Durable Power of Attorney for Health Care Act [1989], Tex. Rev. Civ. Stat. tit. 71, ch. 20, art. 4590h-1 (Vernon Supp. 1990). Newman v. William Beaumont Army Medical Center, No. EP-86-CA-276 (W.D. Tex. Oct. 30, 1986) (Hudspeth, J.). In re Guardianship Estate of Petersen, No. E117,982 (Tex. Dist. Ct. Jefferson County Aug. 4, 1983) (Thomas, J.).

Utah

Utah Personal Choice and Living Will Act [1985, 1988], Utah Code Ann. Sec. 75-2-1101 to -1118 (Supp. 1990).

Vermont

Vermont Terminal Care Document Act [1982], Vt. Stat. Ann. tit. 18, Sec. 5251 to 5262 and tit. 13, Sec. 1801 (1987). Vermont Durable Powers of Attorney for Health Care Act [1987], Vt. Stat. Ann. tit. 14, ch. 121, Sec. 3451 to 3467 (Supp. 1988).

Virginia

Virginia Natural Death Act [1983, 1988, 1989, 1991], Va. Code Sec. 54.1-2981 to -2992 (Supp. 1989 & H.B. 1615, signed March 25, 1991). Virginia Durable Power of Attorney Act [1954, 1968, 1987], Va. Code Sec. 11-9.1 to -9.4 (Supp. 1989), health care decisions authorized by Substituted Consent Act, Va. Code Sec. 37.1-134.4 (Supp. 1989 & H.B. 1727, signed March 20, 1991) & ____ Opinons of the Attorney General ____ (Sept. 18, 1990). Alexandria Hospital v. McLellan, No. CH 13009 (Va. Cir. Ct. Jan. 19, 1982) (Grenadier, J.). Hazelton [sic] v. Powhatan Nursing Home, Inc., No. CH 98287 (Va. Cir. Ct. Fairfax County Aug. 29), order signed (Sept. 2) (Fortkort, J.), appeal denied, Record No. 860814 (Va. Sept. 2, 1986), 6 Va. Cir. Ct. Op. 414 (Aspen 1987).

Washington

Washington Natural Death Act [1979]. Wash. Rev. Code Ann. Sec. 70.122.010 to -.905 (Supp. 1990). Washington Durable Power of Attorney - Health Care Decisions Act [1989], Wash. Rev. Code Ann. 11.94.010 (Supp. 1989). In re Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983), modified, In re Guardianship of Hamlin, 102 Wash.2d 810, 689 P.2d 1372 (1984). In re Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987), modified, 757 P.2d 534 (1988). In re Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984). Strickland v. Deaconess Hospital, 47 Wash. App. 262, 735 P.2d 74 (Ct. App.), review denied (Wash. July 1, 1987).

West Virginia

West Virginia Natural Death Act [1984], W. Va. Code Sec. 16-30-1 to -10 (1985). West Virginia Power of Attorney Act [1990], W. Va. Code Sec. 16-30a-1 to -20 (Supp. 1990).

Wisconsin
Wisconsin Natural Death Act [1984, 1986, 1988], Wisc. Stat. Ann. Sec. 154.01 to -.15 (West 1989). Wisconsin Power of Attorney for Health Care Act [1990], 1989 Wisc. Act 200 (H.B. 305 signed April 12, 1990). In re Guardianship of Welch, No. 89GN30 (Wisc. Cir. Ct. Eau Claire County June 21, 1989) (Peterson, J.), appeal filed, No. 89-1197 (Wisc. Ct. App. 1989).

Wyoming
Wyoming Living Will Act [1984, 1985, 1987], Wyo. Stat. Sec. 35-22-101 to -109 (1990). Wyoming Durable Power of Attorney for Health Care Act [1991], Wyo. Stat. Sec. 3-5-201 to -214 (H.B. 300, signed March 4, 1991).

United States
Patient Self-Determination Act [1990], OBRA of 1990 Sec. 4206 & 4751. Bowen v. American Hospital Association, 476 U.S. 160, 90 L. Ed. 584, 106 S.Ct. 2101 (1986). Cruzan v. Director, Missouri Department of Health, et al., 487 U.S. ____, 111 L.Ed. 2d 224, 110 S. Ct. 2841 (1990).

See Also
Uniform Rights of the Terminally Ill Act [1985, 1987, 1989], Sec. 1-18, 9A U.L.A. 456 (Supp. 1990).

STATUTES AUTHORIZING SURROGATE DECISIONMAKING

Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, Ark. Code Ann. Sec. 20-17-214 (Supp. 1987).

Connecticut Removal of Life Support Systems Act, Conn. Gen. Stat. Sec. 19a-571 (Supp. 1989).

Florida Life Prolonging Procedure Act, Fla. Stat. Ann. Sec. 765.07 (H.B. 513 enacted June 30, 1990).

Hawaii Medical Treatment Decisions Act, Hawaii Rev. Stat. Sec. 327D-21 (Supp. 1988), as interpreted by In re Guardianship of Crabtree, No. 86-0031 (Hawaii Fam. Ct. 1st Cir. April 26, 1990) (Heeley, J.).

Iowa Life Sustaining Procedures Act, Iowa Code Ann. Sec. 144A.7 (1989).

Louisiana Declarations Concerning Life-Sustaining Procedures Act, La. Rev. Stat. Ann. Sec. 40:1299.58.5 (West Supp. 1989).

Maine Uniform Rights of the Terminally Ill Act [1985, 1990], Me. Rev. Stat. Ann. tit. 18a, Sec. 5-701 to -714 (H.B. 1497 signed April 17, 1990.

New Mexico Right to Die Act, N.M. Stat. Ann. Sec. 24-7-8.1 (1986).

North Carolina Right to Natural Death Act, N.C. Gen. Stat. Ann. Sec. 90-322 (1985).

Oregon Rights with Respect to Terminal Illness Act, Or. Rev. Stat. Sec. 97.083 (1984).

Texas Natural Death Act, Tex. Rev. Civ. Stat. Ann., art. 4590h-Section 4(c) (Vernon Supp. 1989).

Utah Personal Choice and Living Will Act, Utah Code Ann. Sec. 75-2-1105(2) (Supp. 1988).

Virginia Natural Death Act, Va. Code Sec. 54:1-2986 (1988); Va. Code Sec. 37.1-134.4 (Supp. 1989).

District of Columbia Health Care Decisions Act, D.C. Code Ann. Sec. 21-2210 (1989).

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